			For State Registrar	State of Maryland	/ Depa	artment of I	Health a	nd Mei	ntal Hygi	g. No.	004	07501
	Physicia		Decedent's Name (First, Middle, Las Ralph					2.	Date of Death Month	Day	Year	3. Time of Death
L	. /Medic	al .		Bregman		4) O': T	- Leasting of	Dooth	02 -	18-1	y of Death	1506 M
33	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town,						
			Holy Cross Hospit 5. Social Security Number 6. S		st birthday)	Silver If Under 1 Year	If Under 2	4 Hrs. 8.	Date of Birth	Mor	9. Birthp	lace (State or Foreign try)
	Funeral Director			∑ M 2□F	58 Yrs.	Months Days	Hours	Min. I	Date of Birth (Month, Day,) PC 29,	1935	Penn	sylvania
	Maryland -f show lied at	tor	10a State 10b County Maryland Prince G		Town or Lo	ocation					1	0d. Inside City Limits 1 ☐ Yes 2 📉 No
3	n with the 3e or 28e st be not	Funeral Director	10e. Street and Number 8920 Hilton Hill	Drive		10f. Zlp Code	20706		10	og. Citizen of Unite	What Cour ed Sta	-
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Maryland of Health and Mental Hygiene. The Maryland of the traumetic event, the Madical Examplation of the rediffied at any injury or other traumetic event, the Madical Examplation.	by Funera	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:1959–19		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🔀 No		jin? (Specif , Puerto Ric	y Yes or No- can, etc.)		ice - Americ ack, White, ify:	
21215-0036	hin 72 hou a. an "natura Medical E	Completed I	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (Q-12)	ducation de completed)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire Lonal Adn	during most			16b. Kind of E		dustry
Maryland 21	12 should be filed within h and Menta! Hygiene. 7 is marked other than "I freumetic event, the Mac	Be	17. Father's Name (First, Middle, Last) Rudolph		vocat.	Olal Adi	· · · · · · · · · · · · · · · · · · ·	r's Name (F	First, Middle, N		me)	
<u> </u>	ould A Men narke netic	2	19a. Informant's Name/Relationship (Bregman	10h Maili	ng Address (Stree			Route Number		Somme	
ā Z	id 2 st Ith and 27 is n treun		Dr. Susan Bregman			Hilton H						
lore,	Pages 1 and nent of Health int: If item 27 iry or other to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Hemoval from State		osition (Name of matory or other pla tan Crem		Dat		Aloxan		own, State Virginia
	permit. Pa Departmer Importent any injury		* 4 □Donation 5 □ Other (Specification of Funeral Service Lices 1.1)				T					and 20705
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death one cause on each line. Hemorrha	. Do not en	ter the mode of dy	ing, such as	cardiac or r	espiratory arre	est,	Maryl	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):							
	ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ								
8760,	certificate be executed nding physician and use as the burial-transit	cai	resulting in death) cast	Due to (or as a consequ	ence or):							
P.O. Box 68	death e atter	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	□Ectopic pregnan □ Other (specify)	су			1 .	ate of deliventh	ery Day Year
	requires that the de een signed by the a nould be detached f	Þ.	Part II. Other significant conditions	contributing to death but not resu	ilting in the	underlying cause g	iven in Part I.	·	23e. Did tob	-		he cause of death? cably 4 ∐Unknown
Division of Vital Records,	elaw hasb je 2 sl	Completed							24a. Was a autops perforr 1□ Yes	y ned?	o. Were auto prior to co death? 1 \(\subseteq \text{Yes}	ppsy findings available impletion of cause of 2 No
ta	sicien: Th certificate irector, pag	BeC	25. Was case referred to medical				26. Place	of Death (Check only on			
<u></u>	Physicien: this certifical	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Nation 2 □	ER/Outpatie	nt 3 DOA			9 5 ☐ Reside			fy)
sion o	ding After fune		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation		28b. Time Injury	M 1[ork? □Yes 2□	No	d. Describe ho			I Davida Alverbag
Divis	Direction	Certification:	3 Suicide 6 Could not l	building, etc. (Specify	·)	•			City or Town	n, State)		al Route Number,
	he Hospital in 24 hours a he Funerel pletely filled	Medical	29a. Certifier 1	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, dea tion and/or i	nvestigation, in my	opinion, dea	nd place, an oth occurred	at the time, d	ate and place	e, and due t	o the cause(s)
	Vaithii C Comp	Σ	29b. Signature and title of certifier	In White	MD		0 4 3	530		9d. Date sign	8/20	
			30. Name and address of person who Raymond M. White	, M.D. 1500 For	est G		Silver	Sprin	ng, Mar	yland	20910	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture &	Span	6					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 2-14-2004 9:00 P. Jess J. Brickman /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 11XIM 2□ F 92 6-14-11 NY Director 087-05-4339 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a, State 10b. County or 28a-f show r than "natural", or items 23e or 28e-f shov the Medical Examiner must be notified at 1 ☐ Yes 2√ No Silver Spring MD Directo Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number #221 20906 USA 14400 Homecrest Rd. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Iter important: If item 27 is marked other than "natural; or Iter sny injury ocother traumatic avent, the Medical Evamina once. 1 ☐ Never Married 2X Married 1 □Yes 2 対 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Business Businessman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bryna (Unobtainable) Jechiel Brickman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3101 Chapel View Dr. Beltsville, MD 20705 Jill Rotter/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Feb. 17, 2004 Glendale, NY Mt. Lebanon Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi F.H. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11800 New Hampshire Ave. Silver Spring, MD 20904 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Chronic Obstructive Pulmonary Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): in any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760 attending physician Physiclan/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? jo 4☐Pregnant at time of death 5 ☐ Other (specify) detached 1 ☐ Yes 2x ☐ No the 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 Munknown Aortic Stenosis Completed 24b. Were autopsy findings available prior to completion of cause of death? Renal Failure has autopsy performed: 2 🗆 No 1 ☐ Yes 2XNo 1 Tyes certificate Congestive Heart Failure Division of Vital Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 DOA 10 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 XNatural 5 Pending 1 Yes 2 No death. investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Feb. 24, 2003 D54347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Neeraj Chapra

31. Date filed (Month, Day, Year)

FEB 25

2004

Box 83819,

32. Régistrar's Signature

Gaithersburg, MD 20883

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L BRO	Please Type or Print in Black					
	State of Maryland / De 1 - For State Unpend ITem#23a,27,Per ME,6829,3/23/04e	partment of Health and N E rtificate of Death	Mental Hygid	ene 2004	075	03
hysician	Decedent's Name (First, Middle, Last) Daniel Lee Brown		2. Date of Death Month FEBRUARY	Day Year 24,2004	3. Time of E	eath M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 10611 Glenwild Road	4b. City, Town, or Location of Death		4c. County of Death	7	

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	Decedent's Name	/First Middle La	21				-	2	Date of Death			3. Time of D	eath
in al	Daniel	Lee Brow	n									3:55a	М
er			e street and number)			4b. City, Town, o	Location of Dea	th		4c. County	of Deatl	h	
	10611 Gl	enwild Ro				Silver				Montg	omer	Y	
	5. Social Security N		ex 7. Ag	e (In yrs. last bir	- ,,	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Date of Birth (Month, Day, Ye	ar)	9. Birth Co	hplace (State or untry)	Foreign
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	Usual Residence of			100 City T	m or 1 -	ontino						10d Joseph City	Limita
_	10a. State	10b. County		10c. City, Tow	ni or Lo	CALION						10d. Inside City	
cto	Maryland	Montg	omery	S	11 v	er Sprin	3					1 ☐ Yes 2	c KR 140
ire	10e. Street and Nun	nber				10f. Zip Code			10g.	Citizen of V	Vhat Co	untry?	
Ē	10611 G1	lenwild R	oad			2090)1			US	SA		
era	11. Marital Status		12. Was Decedent	Ever in U.S.	13.	Was Decedent of H		Specif	y Yes or No-	14. Rac	e - Ame	rican Indian,	
Für	1 Never Marri	ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ 1	10				ITO MIC	an, etc.)		k, White		
Be Completed by Funeral Director	3 Widowed	4 \Divorced	If Yes, Give Year or Dates:			1□ Yes 2≧ No	Specify:			Specify	«Whi	Lte	
ed		15. Decedent's Ed		16a.	. Dece	dent's Usual Occup	ation		168	. Kind of Bu	ısiness/l	Industry	
oiet		ify only highest gra	ide completed)		(Give	kind of work done DO NOT use retired	during most of wo	orking					
E	Elementary/Secon	ndary (0-12)	College (1-4or 5		Геас	cher				Educa	tion	1	
č	17. Father's Name ((First, Middle, Last)		1			18. Mother's Na	ıme (F	irst, Middle, Mai				
Be											•	~ ~ **	
ဥ		seph Brown		1					Elizabe				
	19a. Informant's Na					ng Address (Street					State, Z	up Code)	
	Gloria El	izabeth 1	Brown/ Mot			1 Glenwil	d Road,					20901	
	20a. Method of Disp		Damoural from Ctare			sition (Name of matory or other plac	e) Fab	Date	ry 27	Location -	City or	Town, State	
	` 4 □Donation	5 Other (Specif	<u> </u>	Park1	Pa			200		kvill	e, M	Maryland	L
	21. Signature of Fu	neral Service Licer	1588 C		22	Name and Addre	ss of Facility	E.	meral U	ome T	20		
) (lu	drow)	Loke		50	Univer	sity Blv	d.	W. Sil	ver Si	orin	g MD	2090
	23a. Part1. Enter th	ne disease, or om	lications that caused ne cause on each lin	the death. Do							17.00	Approximate	
	shock, or hear Immediate Cause (1									Interval Betwee Onset and De	eath
	disease or condition resulting in death)		α.			complicat	ing bronch	ıtis	3				
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	Sequentially list con	nditions,	b		0								
lue	Sequentially list con if any, leading to im cause. Enter Unde	rlying	Due to (or as	a consequence	OI):								
аш	that initiated events	injury	c										
Ä	resulting in death) L	_ast	Due to (or as	a consequence	of):								
an/Medicai Examiner			d										
edi					_								
Ž	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcome							23d. Dat	e of deli	very	
	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death time of death		Ectopic pregnancy Other (specify)				Mo		Day Ye	ar
YSI	1 ☐ Yes 2 ☐ 9 ☐ Unknown	N0 \	9□ Unknown			(
Completed by Physic		icant conditions	ontributing to death b	ut not resulting in	n the !!	nderlying cause on	en in Part I		23e. Did tobacc	o use conti	ribute to	the cause of dea	ath?
þ	antin. Other signi	.ount conditions (Simplify to death b	ar nor resulting ii	uio u	ilasiiyiiig causa giv	on HIT wills		1 ☐ Yes		3 Pro	1	
ted									I LI THS	ZUNO	3Uri(opany 4 (CIOII	WI IO ANT
ple									24a. Was an autopsy	24b. \	Vere au	topsy findings av	allable
E									performed	? 0	ieath?		-50 51
ٽ ه	25. Was case refer	red to medical					26. Place of De	ath /C	1 Yes 2	140	71.85	20110	
Be	examiner?		Hospital:	- aC.500		oth Oth	06			a 🗆 🗆	/C	4.)	
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o	1 XNatural	5 Pending	(Month, Da	Year)	Injury	Wor	K?	200	. Describe now I	ijary occurr			
cat	2 Accident	investigation 6 Could not b					Yes 2□No	_					
Ĕ	3 ☐ Suicide 4 ☐ Homicide	determined	e 28e. Place of Injubulding, etc.	ury - At home, fa c. (Specify)	arm, str	eet, factory, office		28f.	Location (Street City or Town, St	and Numbi ate)	er or Ru	ral Route Numbe	9 <i>1</i> ,
Ser													
Medical Certification;	29a. Certifier		ysician: To the best										
dic	(Check only one)	2 X Medical Exar	niner: On the basis of and manner sta		nd/or in	vestigation, in my o	pinion, death occ	urred a	at the time, date	and place, a	and due	to the cause(s)	
Re	29b. Signature and	title of certifier				29c. Licens	e number		29d.	Date signed	(Month	n, Day, Year)	
) -1.	1 1	Man 1.	-4		00	ME		FEB	RUARY	24,	2004	
	- clau	ther of		ng M		- 1							
	30. Name and addre	~ ~	completed cause of d				troot T	2-14	timoro	Marra	and.	21201	
	asha	L (TV	eenberg	M.D.		11 Penn S	LLEEL, I	жЦ	стиоте,	JAT Y	an KC	ZIZUI	
. '	31. Date filed (Moni	th, Day, Year)	32. Registr	ar's Signature	,	,							

State

FEB 26 2004

parks

State of Maryland / Department of Health and Mental Hygiene 2004 07504 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Ź2, February 2004 7:45 Marguerite T. Brown /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner spital Olney

7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Jan. 15, 1912 Montgomery General Hospital Montgomery Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F Washington, DC 578-32-3255 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or iteme 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director Silver Spring Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3227 Bel Pre Road 20906 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Payroll Clerk Federal Government marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H If Item 27 is marked off ir other traumatic even Be Clarence Edward Bracey Lillie Mae Burch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard T. Brown/ Son 8201 16th Street, Silver Spring, MD 20910 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete February 26 ō permit. Pages Department of Important: If it eny injury or o 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery Washington, DC 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of-Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as e consequence of) Carcinana Examiner 121 Sequentially list conditions, any leading to minerials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examiner the death certificate be executed and Due to (or as a consequence of): buriaj-1 physician s the burial Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 25 No
9 Unknown Month Day for 4 Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page this certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes Division of Vital director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes No 2 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After or Attending 5 Pending Natural death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) fil ed in by 4 | Homicide within 24 hours after To the Funeral Direct ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 23, 2004 045285 elleman 30 Name and address of per a who completed cause of death (Item 23a) ype. Print) # 113, Salver String. ILU MWYERS Myryles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 25 2004 oaks Registrar

		1 = For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F		Reg	ene 1. No. 2004	07505
Physi /Med Exam	dical	Decedent's Name (First, Middle, L Josephine Louis 4a. Fecility Name (If not institution, gi	e Butler		4b. City, Town, o	r Location of Death	2. Date of Death Month February	Dey Yeer 21, 2004 4c. County of Death	3. Time of Death
Funera Directo		Washington Adve 5. Social Security Number 6. 257-26-9517 Usual Residence of Decedent	Sex 7. Age	ital o (In yrs. last birthday) 88 Yrs.	Takoma If Under 1 Year Months Days	Park If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Y Apr. 8, 1		npface (State or Foreign untry)
deeth with the Maryland ma 23a or 28a-f show	ector	10a. State 10b. County DC None. 10a. Street and Number		10c City, Town or Le			100	. Citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
IIIG KIKIPOSO be fited within 72 hours after death with the Marylar tal Hygiene. In other then "neturel", or items 23e or 28e-f show event, I'm Medical Experience must be notified at	by Funeral Director	125 Michigan A 11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1	Ever in U.S. 13.	20017 Was Decedent of H	7 Hispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecify Yes or No-	USA 14. Race - Amer Black, White Specify:	ncan Indian,
id K I K I 3-0030 filed within 72 hours after I Hygiene. other than "natural", or ite	Completed	15. Decedent's 8 (Specify only highest g	Education rade <i>completed)</i> College (1-4or 5- 4	+) (Give	DO NOT use retired	during most of work	ng	b. Kind of Business/li ederal Gov	ndustry
larylarid 2 should be file and Mental Hy is marked oth	To Be	17. Father's Name (First, Middle, Las Edward George Bu 19a. Informant's Name/Relationship	ıtler			18. Mother's Name	ne Jet	iden Surname)	
1 and 1 Health term 27 other tr		Frances Butler, 20a. Method of Disposition 1 □ Burial 2 ③Cremation 3	☐Removal from State		osition (Name of matory or other plac	ce)	Date 20	ington, D. C lo. Location - City or T	Town, Stete
= : F F F	ODCE	21. Signature of Funeral Service Lice Allian	Byl		2. Name and Addre rancis J. 00 Univer	ss of Facility Collins Sity Blvd	Funeral 1		
Physiciai /Medica	al	23a. Part 1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each lin	the death. Do not en e. a consequence of):	Puly	ng, such as cardiac o	m kol	ism	Approximate finterval Between Onset and Death
ate be executed ate be executed bysicien and the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasf	b. Due to (or as a Due to (or as a d.	a consequence on:	ante totou	ng de	d Hy	dy	
death certific	Physiclan/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetaf death 3	Ectopic pregnancy Other (specify)	/		23d. Date of deliving Month	very Day Year
The law requires that the ate has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions	contributing to death bu	at not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of death?
The lav	e Completed	25. Was case referred to medical				OC Plans of Parall		prior to co	opsy findings available ompletion of cause of 2 No
Physician: rthis certificanal director,	ToB	examiner? 1 Tes 2 No		nt 2 ER/Outpatie	nt 3 DOA Oth	ar	n <i>(Check only one)</i> me 5 ☐ Residend	ce 6 ☐Other (Speci	ify)
Attending Part death. ector: After the tuneral	Certification:	27. Manner of Death Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not			Wor	k? Yes 2 □ No	28d. Describe how		
DIVISION To the Hospitel or Attendition 24 hours after death To the Funeral Director: 4 completely filled in by the fu		4 Homicide determine		ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (Stree City or Town,	et and Number or Rur State)	al Route Number,
he Hosp in 24 hou he Fune pletely fi	edical	29a. Certifier Certifying F (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examination and/or in	h occurred at the tir vestigation, in my o	me, date and place, ppinion, death occurr	and due to the caused at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
With Con	Σ	29b. Signature and title of certifier	Tes		29c. Licens	,		Date signed (Month.	
5		30. Name and address of person who	o completed cause of de	eath (Item 23a) (Type,	Print) U4 Mall tor	0998 1 ST /	faculti	ulle MI	21,2004
S Regis	State strar	31. Date filed (Month, Day, Year) FEB 2 4 2		r's Signature	Spark		0		1

		1	For State Registrar Unpend Item#23	State of A.,27,Per	f Maryland / E ME,G829,3/16	Depa	ertment of He	ealth an Death		Reg. No	$Z \cup U \cup U$		7506
	ician	ı	i. Decedent's Name <i>(First, Middle, Last)</i> WILLIAM		BLAKE				2. Date of D Month FEB	Da	y 2004	r	Time of Death
	dical niner		la. Facility Name (If not institution, give 5101 LEROY CORHAM		mber)		4b. City, Town, or FAIRMOU			1	:. County of De PRINCE		GES
Fune: Direct		5	5. Social Security Number 6. Se 212-76-0250	X M 2□F	7. Age (In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	Hours M	Hrs. 8. Date of Bi Min. (Month, D March	rth ay, Year, 25 1	9. B	irthplece (Country) M	State or Foreign
anyland how	or or	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town								side City Limits
ith the N or 28a-1	Director		D · C ·		was	PITTI	10f. Zip Code			-	itizen of What		
If e, IMATYIATIO ZIZIO-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene If Health and Mental Hygiene Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event. Its Medical Exprime routes be notified at	v Funeral		11. Marital Status 1 X Never Married 2 Married	Armed Fo 1 ☐ Yes If Yes, Giv	edent Ever in U.S. prces? 2 [X]No ve		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☑ No	20019 spanic Origin n, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)		United 14. Race - Ar Black, WI Specify:	nerican In	dian,
A I A I D-UUSO od within 72 hours aft giene er then "natural", or	Completed by	ממוש	3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a.	(Give	dent's Usual Occupa kind of work done di DO NOT use retired) Labore	uring most of	working	16b. F	Cind of Busines	ss/Industry	
Maryland Z1Z1: Id 2 should be filed within the and Mental Hygiene It is marked other then the traumatic event.	Re Cor		8th 17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle Mable Spr		n Sumame)	•	
2 should and Me ie mark	F	2	Joseph Blake 19a. Informant's Name/Relationship (7)	rpe, Print)	196	. Maili	ng Address (Street a		r Rural Route Numi	per, City	or Town, State		a)
of Health if item 27			Darlene Robinson / 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F		20b. Place of cemeter	f Dispo	Pinebrook sition (Name of natory or other place)	Landove	20c. L	ocation - City	or Town, S	
parmit. Pages 1 and 2 Department of Health a Important: If Item 27 is	Suce.		4 □ Donation 5 □ Other (Specify, 21. Sign, ure of Funeral Service Livens	-	Chesa	22	ake Cremat Name and Addres 1425 Mary]	s of Facility	Capitol 1	Mort	Beltsvi uary, I h., DC		
Physici /Medio Examin	an :al		23a. Part1. Enter the disease, dromp shock, or heart failure. List/only of Immediate Cause (Final disease or condition resulting in death)	Athen	caused he death. Do each line. osclerotic Ca	Not en	er the mode of dying	, such as car	diac or respiratory	arrest,	11.,	App	roximate val Between et and Death
icate be executed physician and the burial-transit		מו רעמווווופו	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequence								
be death certification the attending	n/Ma	D -	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	itcome of pregnancy birth 2 Fetal death nant at time of death lown		Ectopic pregnancy Other (specify)				23d. Date of o	delivery Day	Year
			Part II. Dther significant conditions or	ntributing to d	leath but not resulting i	in the u	nderlying cause give	n in Part I.		tobacco	use contribute	to the car Probably	use of death?
He la he la e has	telamo	Completed								opsy formed?	prior t death	o complet	ndings available ion of cause of No
VITA sician: certific	Œ	מ	25. Was case referred to medical examiner? ¹XXY es 2 □ No	Hospital:	Inpatient 2 ER/O	utpatie	nt 3□ DOA Othe		Death (Check only		6 XOther (S	pecify) I	AT SCENI
ding After	iffootlop:	Ceruicanon:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	28e. Place		Time of Injury	M 1 1	at ? ∕es 2 □ No		(Street a	and Number or	Rural Rou	ite Number,
Hospita 4 hours Funeraf		edical cer	29a. Certifier 1 Certifying Physics (Check only one)	iner: On the b	e best of my knowledg pasis of examination ar	e, deat	h occurred at the tim vestigation, in my or	e, date and p inion, death	place, and due to the	e cause(:	s) and manner nd place, and d	as stated. lue to the	cause(s)
To the Hos within 24 ho To the Fun		Med	29b. Signature and title of certifier	/ K	1 rus		29c. License	number .M.E			ate signed (Mo	onth, Day, , 20(
2	State		30. Name and address of person who of the state of the st	1, Kinco			enn Street	, Balt	imore, M	aryl	and 212	201	

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 7 Day Physician 4:21 A M Wattimena Bonnette /Medical Veronica 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton Prince George's Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 4 29 Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🂢 F 577-62-1095 83 Indonesia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Itama 23a or 28a-f ahow Ita Medical Examinar must be notified at 1 Yes 2 No Director P.G. Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 Stuart Lane 20735 U.S. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Service Food Preparer 12 permit. Pages 1 and 2 should be filed:
Department of Health and Mental Hyglic
Important; if item 27 is marked other t any injury or other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sophia Mitales Radolphis Wattimena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Bonnette -Son 7309 Milligan Lane, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l 2-27-04 Arlinton, VA 22. Name and Address of Facility Bonnette & Asoc. Funeral Home 21. Signature of Funeral Service Licensee 2504 28th Street, N.E., wDC 20018 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit resulting in death) Last Due to (or as a consequence of): nding physicien Physician/Medical use as the Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a o. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Othersignificant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, Hente myorarchal Interction 1 Yes 2 No 3 Probably 4 Unknown should should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ √No 24a. Was an page 2 this certificate has autopsy performed 1 Tes 2 No completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident or Attandate death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hospital within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number D0055120 teb 17 2004 mi) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washing for DC 20032 Richard Palmer mo 1328 Southern Avenu SE Suck 31V 31. Date filed (Month, Day, Year) State FEB 2 0 2004 Registrar

DHMH 17 Rev 1/2001

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			State of Marylan		artment of Hortificate of L			711111	07508
			Registrar 1. Decedent's Name (First, Middle, Last)		Tillicale Of L	Jeani	2. Date of Death	g. No	3. Time of Death
	Physici		Sharon	Ba	aswell		Honth Februs	Day Yeer	11:12 AM
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	/	4b. City, Town, or	Location of Death	2019	4c. County of Deet	h
	LAUITIII	٠,	THE TOOK HOKINS HES	Spip1	152/4/	DORE (1	XX		
_	Funeral	•	5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birti	nplace (State or Foreign untry)
	Director		579-76-2641 ^{1□ M 2} F 47	Yrs.	Monars Days		July 21	,1956 D.	
	pu *		Usual Residence of Decedent 10a, State 10b, County 10c, C	ity, Town or L	ocation				10d. Inside City Limits
	f ahow	0	Md. PG. Ox	•	i11				1 AYes 2 No
	the M. 28a-f	ect	10e. Street and Number		10f. Zip Code		10	og. Citizen of What Co	untry?
	s within 72 hours after death with the Maryland Jiene r than "natural", or Itame 23a or 28e-f ahow The Medical Examine must be notified at	Funeral Director	5820 Ottawa Street		20745			USA	,-
	death The 2%	era	11. Marital Status 12. Was Decedent Ever in U	J.S. 13.	Was Decedent of His	spanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
٥	after dea or Itame		1 XNever Married 2 Married 1 Yes X No		If Yes, specify Cubar 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, White Black	e, etc.
2-0036	within 72 hours after ene. than "neturel", or Ite he Medical Erannin	1 by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 LI Yes 2121-No	Specify:		Specify:	
7	72 hours "natural", idical Exe	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa a kind of work done di DO NOT use retired)	tion uring most of working	19	6b. Kind of Business/	ndustry
Z	han '	mp	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired) lerk			Fed. Go	vernment
N	filed v Hygie other t		12th 17. Father's Name (First, Middle, Last)			18. Mother's Name	(First Middle M		
and	D d la D	Be	Willie Dee Braswell					Brown Bra	swell
Ξ	should ind Men ind marke umatic	ို	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street a			City or Town, State, 2	
Ø ≥	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		Carla D. Webb (Daughter)					Heights, N	, ,
ē,	of Heal		20a. Method of Disposition 20b.	Place of Disp	osition (Name of	D		Oc. Location - City or	
<u> </u>	ages ent of it: If i		1 💢 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)		matory or other place Mem. Ce	'	/04 T	Landover,	Md.
Saltimor	nit. F entme ontan injur		21. Signature of Funeral Service Licensee		2. Name and Address			F/S/Inc	
ä	permit. Pages 1 Depertment of He Important: If iter any injury or oth		Page 8/ mail	i		11.		C.20001	•
			23a Part Enter the disease, or complications that caused the dea						Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		70 (Onset and Death
	/Medical		disease or condition resulting in death) A Due to (or as a conse		BILEAST	CANCEIC			& MONTHS
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	n =	ner	if any, leading to immediate cause. Enter Underlying				_		
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Ď,	ate be executed hysicien and the burial-transit	Ě	resulting in death) Last Due to (or as a conse	quence of):					
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٥ ×	that the death certific ed by the attending p detached for use as:	hysician/Me	IF FEMALE: 23c. If yes, outcome of pregr	nancy					
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Į.	requires that the een signed by th hould be detache	۵.	Part II. Other significant conditions contributing to death but not re	sulting in the u	underlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
as,	uires that signed l	d by					1 🗆 Yes	s 2 No 3 Pro	bably 4 QUnknown
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ě	0 5 9	шс					autopsy	ed? prior to death?	ompletion of cause of
Vital	an: 1 tifical tor, p	e C	25. Was case referred to medical			26. Place of Death			2 No
	Physiclan: The this certificate ral director, pag	O B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2] ER/Outpatie	Otho	-		nce 6 Other (Spec	ifv)
וס ר	ding Ph h. After th funeral	T:u	27. Manner of Death 28a. Date of Injury	28b. Time of	of 28c. Injury Work			w injury occurred	
<u></u>	tendin death. tor: Af the fur	atio	2 Accident investigation	,		es 2 □No			
Division	al or Attending P s after death. sl Director: After i d in by the funera	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - Athermined building, etc. (Special Countries)	nome, farm, st	reet, factory, office	2	8f. Location (Street) City or Town,	eet and Number or Ru. State)	ral Route Number,
	To the Hospital or Attentwithin 24 hours after deall To the Funerel Director: completely filled in by the	O							
	Hosp 4 hot Fune ely fii	edical	29a. Certifier (Check only (C	owledge, deal ation and/or in	th occurred at the time ivestigation, in my opi	e, date and place, a inion, death occurre	nd due to the cau d at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	the the	Med	one) and manner stated. 29b. Signature and title of certifier		29c. License	number	20	d. Date signed (Month	Day Vansi
	T W S		South A Berlows up	INTER	N RES-		1	BRUARY 11	
0	(Deint				- 1
	-(4)		30. Name and address of person who completed cause of death (fte SCOTT FACEND WITZ JOHNSHOPKINS HT			WOLFE ST	REET B	ALTILLINE.M	ANTILAND ZIZE;
6.	Sta	te							
	Registr	-	31. Date filed (Month, Day, Year) FEB 1 9 2004	App	W.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Day Year Month BUSH JAMES **EDWARD** 02 -09 -2004 4a Fecility Neme (If not institution, give street end number) 513 Balboa Ave. 4b. City, Town, or Location of Death 4c. County of Deeth Prince George Capitol Heights If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 250 – 50 – 3485 6. Sex 1 X M 2 ☐ F Months 65 Yrs March 22, 1938 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 □ No MD. Prince George Capitol Heights 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number 20743 513 Balboa Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? ↑☐ Yes 2☐ No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working Blogie. De NOT use retired Manager 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Montgomery Co. Md Elementary/Secondary (0-12) 12th College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Walter James Bush Mattie Inabinett 19a. Informant's Name/Relationship (Type, Print) Doris Blackwell – Bush, Wife 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 513 Balboa Ave. Capitol Heights, MD. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/18/04 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, MD. Cheltenham Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility MOIZEN Bianchi F.S. 814 Upshur St. NW, Washington, DC. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC ARREST Due to (or as a consequence of): LEFT VENTRICULAR HYPERTROPHY Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPERTEN SION Due to (or as e consequence of) 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy 2 No 1 □ Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending investigation

Physician /Medical Examinar

Examiner

Physiclan/Medical

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Completed

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edical Certification: To

3 T Suicide

29a. Certifier (Check only one)

4 \ Homicide

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any Injury or other treumetic event, the Medical Examiner must be norified at

3altimore, Maryland 21215-0020

attending physician and for use as the burial-transit The law requires that the death certificate be executed signed by the a certificate has b lirector, page 2 sl

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, death. within 24 hours a

To the Funeral C

completely filled

15 State

Registrar

himpmon

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Yeer) 2-13-2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONNECTIWIT AVE, KENSINGTON, MD 20895 MENON 10901

31. Date filed (Month, Day, Year)

29b. Signature end title of certifier

FEB 1 8 2004

6 Could not be determined



DHMH 16 Rev 6/95

			For State Registrar	State of Marylan		artment of tificate of			Reg. No	2004	07510
E	Physicia	_	Decedent's Name (First, Middle, Las SYLVANES	BERRY				2. Date of Month FEBRU	Da		3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town	, or Location of D			. County of Death	
			Prince George's				Cheverly			rince Ge	
3	Funeral Director		410-56-1822	7. Age (In yrs. 3tM 2□ F 67	last birthday) Yrs.	If Under 1 Yea Months Day		Hrs. 8. Date of (Month, Dec.	Day, Year,	9. Birth Cou 36 Miss	plece (State or Foreign ntry) issippi
	land ow	-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	e Many sa-f eh	ctor	Maryland Prince G	eorge's	Fort V	Vashingt			1		1 ☑ Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show Finals by rudiffed at	Funeral Director	10e. Street and Number 12900 Chalfont Av	enue		10f. Zip Code 2074			10g. Ci	tizen of What Cou USA	ntry?
	ems 2	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of If Yes, specify Co	f Hispanic Origin uban, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ameri Black, White,	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event. It a Medical Examiner treat he rediffied at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 ☐ No If Yes, Give Year or Dates:		1⊡Yes 2⊠gN	lo Specify:			Specify: Bla	
15-(in 72 h n "natu Nedica	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occ kind of work dor DO NOT use reti	cupation ne during most of ired)	working	16b. F	(ind of Business/Ir	dustry
212	ed within rgiene.	Com	Elementary/Secondary (0-12)	2	Ma	ason	1			eral Gov	ernment
Maryland	12 should be filed within had Mental Hygiene. 7 is marked other than "reumatic event, tre Mes	To Be	17. Father's Name (First, Middle, Last) Ezell Berry					Name (First, Mid ie Lee P		n Sumame)	
Man	12 sho h and I 7 is me treume		19a. Informant's Name/Relationship (7						-	or Town, State, Zij	
Baltimore, I	permit. Peges 1 and 2 Department of Health a important: If item 27 is eny injury or other tre		Gladys P. Phelps/ 20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □	Removal from State	Place of Dispo cemetery, crea	sition (Name of matory or other p	nlace)	Date	20c. L	ngton, M	own, State
Itim	artment ortant: injury		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Light)			Ll Cemet		-25-2004	_	tland, Ma neral Ho	
Ba	permi Depar impol eny ic		Simbaly (1)	wood one	1	4308 Sui	tland Ro	oad Suit	land,	MD 207	
	Physician /Medical Examiner		23a. P. rt1. Enter the disease, or composition, or heart failure. List only limmediate Cause (Final disease or condition resulting in death)	olications that caused the deat one cause on each line. a. Chronic Obsi Due to (or as a consect Hypertension	tructiv			rdiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
0,	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect c.	uence of):						
68760,	cate be ohysici the bu	dical		. d.							
P.O. Box 6	it the death certificate be every the death certificate by the attending physician tached for use as the burians.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnative birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous forms of the second points o	Ideath 3	Ectopic pregna Other (specify)				23d. Date of deliv Month	ery Day Year
	juires that n signed b	Ď	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause	gwen in Part I.				the cause of death?
Vital Records,	The law requires that the death ate has been signed by the atter page 2 should be detached for u	Completed						— a	Vas an utopsy enformed? es 212 N	prior to co	opsy findings available ompletion of cause of
ita		Be C	25. Was case referred to medical examiner?				26. Place of	Death (Check or			
) t	Physicien: this certific ral director,	မ	1 ☐ Yes 2 ☒ No		ER/Outpatier	11 3 DOX		-		6 Other (Speci	fy)
ono	Jing After fune	ıtion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		njury at Vork? □ Yes 2 □ No		ibe now inju	ury occurred	
Division of	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: a completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st fy)	reet, factory, offic	се		on (Street a Town, Stat	nd Number or Rur 'e)	al Route Number,
	Hospitel 24 hours a Funeral istely filled	Medical C	29a. Certifier 1X Certifying Ph (Check only only) 2 Medical Exam	niner: On the best of my known and manner stated.	owledge, deat ation and/or in	h occurred at the evestigation, in m	time, date and p y opinion, death	place, and due to occurred at the til	the cause(s	s) and manner as and place, and due	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				ense number			ate signed (Month,	
	1		(C				D58182		Feb	ruary 21	, 2004
2	(5)	1	30. Name and address of person who Donald C. George		m 23a)(Type, pital l		Chever	ly, Mary	land		
	Sta		31. Date filed (Month, Day, Year)	■32. Registrar's Sign	ature			J's same J			
	Regist	rar	FFR 2 3 2004	Kenter M.	Links						

DHMH 17 Flev 1/2001

ORIGINAL

Funeral

Director

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exeminar must be redified at

al Hygiene.

permit. Pages 1 and 2 should be fit Department of Health and Mental Hy important: if Nem 27 is marked other any injury or other traumatic access.

Physician

Examiner

certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

/Medical

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page 2 should

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death.

after death Director:

filled in by

and

physician

within 72 hours after

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200 L 07511 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Edward Bovd Willie FEBRUARY 15, 2004 11:45a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SMITH VILLAGE COURT SILVER SPRING If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 Social Security Number 1**X** M 2□ F 71 March 6,1932 South Carolina 247-48-0169 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 X Yes 2 ☐ No Montgomery Silver Spring Maryland Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 United States 9 Smith Village Court Was Decedent Ever in U.S.

13. Was Decedent of Hispanic Origin? (Specify Yes or NoAmed Forces?

AYes 2 No Feb. 19

15. Was Decedent of Hispanic Origin? (Specify Yes or No16. Was Decedent of Hispanic Origin? (Specify Yes or No17. Was Decedent of Hispanic Origin? (Specify Yes or No18. Was Decedent of Hispanic Origin? (Specify Yes or No18. Was Decedent of Hispanic Origin? (Specify Yes or No19. Was Decedent of Hispanic Origin? (Specify Ye Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Black. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Feb.1958 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Dept. of Health Elementary/Secondary (0-12) College (1-4or 5+) & Human Services years Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Minnie Ida Ragin Jenkins Boyd Edward 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15784 Panola Road; Pinewood, South Carolina 29125 Rev. Roosevelt Boyd (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 24, 2004 Clarendon County, 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State New Hope A.M.E. Cemetery Pinewood, South Carolina 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee R. N. Horton Company Morticians, Inc. narrak 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition "Smoke inhalation and thermal injury complicating atterose bratic cardiouse dar resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 5 ☐ Other (specify) 4☐ Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No autopsy performed? 1 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE Hospital: 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: Deceased in house Fine □Natural 5 Pending 6:34AM 1 ☐ Yes 2 No -15-04 investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) G Sm th Village 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Silver Spring MD. 20904 nome 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical (Check only one)

within 24 hours a To the Funerel L

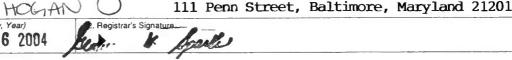
State Registrar

31. Date filed (Month, Day, Year) FEB 2 6 2004

SUSAN

30. Name and address of person who completed cause

29b. Signature and title of gertifi



DHMH 17 Rev 1/2001

death (Item 23a) (Type, Print)

29c. License number

OCME

29d. Date signed (Month, Day, Year)

FEBRUARY 16,2004

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2001 Certificate of Death 2. Date of Death Month Mamie Richardson Boyd FEBRUARY 15, 6:40 a 2004 4c. County of Death 4b. City, Town, or Location of Death

Physician /Medical Examiner

Funeral Director with the Maryland

irsi', or itams 23a or 28a-f shov Examiner must be notified at

death v permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene, Importent: If Item 27 is marked other than "natural" or limany injury or other traumett.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

the attending physician and hed for use as the burial-transit has page 2 certificate funeral director, After death

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

after death Director: completely filled in by the ŏ To the Hospitel o within 24 hours aff To the Funerel D Medical

State Registrar

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number) MONTGOMERY SILVER SPRING SMITH VILLAGE COURT If Under 1 Year If Under 24 Hrs. B. Date of Birth / Month, Day, Year 1931 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 K F 73 230-38-7219 February 15, Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 X Yes 2 □ No Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 United States 9 Smith Village Court Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Holy Cross Hospital Registered Nurse 4 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Richardson Carter Charles Lucy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29125 Rev. Roosevelt Boyd (Brother-in-Law) 15784 Panola Road; Pinewood, South Carolina 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 24, 2004 Clarendon County, Pinewood, South Carolina * 4 □ Donation 5 □ Other (Specify) New Hope A.M.E. Cemetery 21. Signature of Funeral Service Licensée R. N. Horton Company Morticians, Inc. namal 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Smokeard scot Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

124 Yes 2 □ No 1 Yes 2 □ No 25. Was case referred to medical examiner?
1 🖄 Yes 2 🗌 No Be 26. Place of Death (Check only one) Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6XXQther (Specify)AT SCENE 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death

28a. Date of Injury (Month, Day Year) 28b. Time of Injury -15-04 6 6 ☐ Could not be

34 AM

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ast nom-

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner is stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

subject

29b, Signature and title of certifier

OCME

29c. License number

29d. Date signed (Month, Day, Year) FEBRUARY 16,2004

house

39-Name and address of person who completed cayes of qeath (Item 23a) (Type, Print)

To NAK MA11 Penn Street, Baltimore, Maryland 21201 MONIGA-ATRICIA 31. Date filed (Month, Day, Year)

FEB 2 6 2004

5 Pending investigation

1 Natural

3 Suicide

29a Certifier

2 Accident

4 Homicide

82. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** MILDRED BALFOUR 23, 2004 2:45 P BLANCHE FEB. /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE JOSEPH RICHEY HOSPICE BALTIMORE 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Hours 1 M 2X F 89 JAN. 19, 1915 NORTH CAROLINA Director 243-10-4973 Usuat Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County or 28a-f ahow the Medical Examiner must be notified at 1 X Yes 2 □ No Director MONTGOMERY **CHEVY CHASE** 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 2810 EAST WEST HIGHWAY Items 23a 20815 UNITED STATES by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE ŏ Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ns any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) Cottege (1-4or 5+) 9 STOCK CLERK GROCERY STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES LEONARD WRIGHT **IDA UNKNOWN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2810 EAST WEST HIGHWAY, CHEVY CHASE, MD 2081
se of Disposition (Name of Date 20c. Location - City or Town, State LOUIS M. BALFOUR 20815 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) COMFORT CEMETERY 02/27/2004 ALEXANDRIA, VA 22. Name and Address of Facility **DEMAINE FUNERAL HOME** 21. Signature of Funeral Service Licensee 5308 BACKLICK RD., SPRINGFIELD, VA Approximate Interval Between Onset and Death 23 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Vital Records, 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2[] NO 1 ☐ Yes 20 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence ther (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To to 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and addresslof person B2. Registrar's Signature 31. Date filed (Month, Day, Year) State 26 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** Month Feb. Mae Bailev 22, 11:17PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🕱 F 253-30-7005 Director 80 Nov. 28, 1923 GA Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Md. P.G. Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8102 Hunters Green Court 20735 United States Funerai 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: Black 3 XWidowed 4 ☐ Divorced The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) Waitress Private 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental Walker Atkins Erma Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8102 Hunters Green Court Clinton, Md. 20735 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and important: If item 27 ie m eny injury or other treum Tarsha Moore/granddaughter Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. 2/27/04 * 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cem. Brentwood, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Pont. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition EREBRAI **Physician** ANOXTA resulting in death) /Medical Due to (or as a consequence of): Examiner METABOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ACTOOSIS Examiner e to (or as a consequence of) attending physician and for use as the burial-transit ARONIC ORSTANCTIVE ATRACT DISEASE Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 1 Yes 2 ₹No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital c within 24 hours at To the Funeral D 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 050862 FEBRUARY 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHERSE (IASS AV. MO) 9831 GREENBELT SUITE 103, LANHAM, MD 20706 31. Date filed (Month, Day, Year)
FEB 2 7 2004 2. Registrar's Signature State Registrar

4	•		State of Marylan		artment of H		Mental Hygi	iene 19. No. 2004	07516
2	- A		Registrar 1. Decedent's Name (First, Middle, Last)		lilicate of t	Jeani	2. Date of Deati		3. Time of Death
	Physici		Lawrence R. Burno				Februar	Day Year	1606 M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	ital	4b. City, Town, or	Location of Deat		4c. Sounty of Death	Bannala
	Funeral		5. Social Security Number 6. Sex 7. Age (Infyrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Q Birthe	place (State or Foreign
	Director		577-52-3407 12KM 2 F 64	Yrs.	Months Days	Hours' Min.	(Month, Day, Aug. 21	1,1939 Was	shington.[
	pu 🛊		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ity, Town or Lo	cation				0d. Inside City Limits
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	h with	O E	3700 Ninth Street SE.		20	032		U.S.A.	
	ems 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
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	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Evacuitar must be rediffied at	Be (17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, M	faiden Sumame)	
2	should nd Men marke umatic	⁶	Eugene Burno	451 44 22			Malone		
<u> </u>	d 2 sh th and 17 Is n treun		19a. Informant's Name/Relationship (Type, Print) Mildred L. Smith/Sister					City or Town, State, Zip	•
กั	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene a first real than "natural", or flems 23e or 28e-1 show other treumatic event, the Medical Evacurar must be notified at		20a Method of Disposition 20b. F	Place of Dispo	IEST VIY sition (Name of matory or other place	-	Date NE	Wash DC 20c. Location - City or To	20032 own, State
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ă	death e atter d for u	iclar	in the past 12 months?]Ectopic pregnancy] Other (specify)			Month	Day Year
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ń	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause give	n in Part I.		acco use contribute to the	. /
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_	To the Hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.	O	29a. Certifier 1□ Certifying Physician: To the best of my kno	owledge, death	occurred at the tim	e, date and place	, and due to the car	use(s) and manner as st	ated.
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	Yot Withi Totl	Σ	29b. Signature and title of certifier	1	29c. License	number	29	d. Date signed (Month, i	Day, Year)
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	Un		30. Name and address of person who completed cause of death (Item	m 23a) (Type, 1	Print)	Drive (W. went.	Marila	
	Sta	te	31 Date filed (Month, Day, Year) 32/Registrat's Signa		39,100	- The C	morely	, land long	- O
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			for State Registrar	State of Maryla	and / Depa	artment of H	Death		ene 2004	07517
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i door	24 hou	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my k niner: On the basis of exam and manner stated.	nowledge, death ination and/or inv	occurred at the time restigation, in my op-	e, date and place pinion, death occu	, and due to the causered at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
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	W -1		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)	line h	lest humt	2-11-06	157
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		-	State of Maryland / De	epartment of Health and Ment Certificate of Death	al Hygien	- COU4 11/31/9
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			313 Oak Manor Drive	Glen Burnie		nne Arundel
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min. (A	ate of Birth Month, Day, Year	
	Director	-	215-28-3702 TSUBURING TO THE TRANSPORT T	<u> </u>	ne 1 19	931 Maryland
	and	ŀ	10a. State 10b. County 10c. City, Town of	or Location	-	10d. Inside City Limits
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	h the	Directo	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	death with the Maryland rms 23a or 28a-f show		313 Oak Manor Drive	21061		USA
	ltems	Funeral		 Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican 	res or No- n, etc.)	 Race - American Indian, Black, White, etc.
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ñ	Ped Per Suppose		Lower B. Beese MOOY83	Wm. Reese & Sons 1 821 West St. Anna	Mortuai polis,	Md. 21401
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Division of Vital Records,	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town, Sta	and Number or Rural Route Number, tte)
	pital ours a eral C		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, and o	due to the cause	(s) and manner as stated.
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			Bayinnah Shahazz Mb	406 B South Crain &	try #	206 6-621061
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Dennis Casey 04-01253

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 07520

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	7.		Decedent's Name (First, Middle, Last	st)				2. Date of De	eath Day	Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	ath	4c.	County of Death	
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	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	s. last birthi Yr	Months Days	Hours Mi	n. (Month, D	ay, Year)	9. Birth Cou	place (State or Foreign intry)
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back	Mo H		10a. State 10b. County	10c. 0	City, Town	or Location			-		10d. Inside City Limits
Mon	E P	tor	Maryland Anne Aru	ndel Ann	apoli	5					1 Tes 2 No
4	or 28a-f show	lre	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	ntry?
4	238	la l	403 Duvall Lane			21403				ed State	
Š	tems tems	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? In, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	 Race - Ameri Black, White 	
2	out be filled within 7.2 hours are locall with the maryans Mantal Hybrid has "seed other than "natural", or items 23a or 28a-f show aftic event, the Medical Examinat must be multipled at	by F	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 🖔 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Specify: Wh	ite
3	atura	ed	15. Decedent's Ed	ducation	16a. C	ecedent's Usual Occup	ation	. 4.5.	16b. Ki	nd of Business/I	ndustry
יו בי	Wa .	Completed	(Specify only highest gra	College (1-4or 5+)	- 1	Give kind of work done of ife. DO NOT use retired	during most or w	vorking			
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7	should be nd Mental marked c	၉	Viron B. Casey			Mailing Address (Street		ite M. M			. 0-1-1
~	A 42 50 M		19a. Informant's Name/Relationship (Katherine Casey /			4 South Har					
ນົ.	Health Health Gm 27		20a. Method of Disposition			Disposition (Name of crematory or other place		Date	,	cation - City or T	
Saltimor	permit. Pages I am Department of Heali Important: If item 2 sny injury or other once.		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State		crematory or other place.		21/2004	Anna	nolis N	Maryland
	ortan injur		21. Signature of Funeral Servicer Licer								al Home, Inc
Ď	Depar Impor		Michael / Slo	ran		147 Duke o	f Glouc	ester St	. Anı	napolis,	MD 21401
del			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do no	-		· ·			Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	Attumosco	Oursi	in Cardio	vaseu	lan D	soa	12	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of						
	-xammer	<u>_</u>	Sequentially list conditions.	b Due to (or as a cons	equence of).					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 10 (01 43 4 60113	equonico oi	,.					
	al-trai	xar	that initiated events resulting in death) Last	C. Due to (or as a cons	equence of):		7			
0/8 0/8	certificate be executed adding physician and use as the burial-transit		(d							
9	ng ph)	Medical									
ם מס	th cer endir r use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	gnancy etal death	3 Ectopic pregnancy	/			23d. Date of deliver Month	very Day Year
	w requires that the death ce been signed by the attendii should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□ Unknown	f death	5 Other (specify)				Tropies -	50,
л Э	hat the d by th setache		Part II. Other significant conditions	contributing to death but not r	esulting in	the underlying cause giv	ren in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
JS,	requires that een signed b hould be deta	l by	Tarrii. Othor significant contains	John James To Godin Lat Not 1					Yes 2		bably 4 Unknown
ecords,	v requ	etec						24a. Wa	s an	24b. Were aut	opsy findings available
ě	has has	Completed						_ aut	opsy formed?	prior to c death?	opsy findings available ompletion of cause of
	ician: Th certificate rector, pag	e Co	25. Was case referred to medical				26 Place of F	1 ☐ Yes Death (Check only	<u> </u>	1 Tes	2 No
5	ysician: is certific director,	To B	examiner? 1	Hospital:	ER/Out	patient 3 DOA Oth		Home 5□Re		6 □Other (Spec	ıfy)
0	ding Phy h. After thi funeral (27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Ti	me of 28c. Injury Wor	y al	28d. Describe	how inju	y occurred	
000	oteath. ctor: Af y the fur	atlc	2 Accident investigation			M 1 🗆	Yes 2 □ No				
Division	of or Attending Physician: after death. Director: After this certific d in by the funeral director,	Certification;	3 Suicide 6 Could not be determined			m, street, factory, office			(Street an own, State		ral Route Number,
_	spitel ours at ours at ours at ours at ours at our outs at out outs at		GOo Coddior 1□ Codifying P	hysician: To the best of my	vnowledge.	death accurred at the til	me date and nis	ace and due to th	e cancele	and manner as	stated
	To the Hospitel within 24 hours a To the Funeral Completely filled it	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	miner: On the basis of exam and manner stated.	ination and	or investigation, in my	pinion, death or	ccurred at the time	a. date and	d place, and due	to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1 //1		29c. Licens	se number		29d. Da	te signed (Month	Day, Year)
	F > F 0		N XXX	w/W		OCME				lary 17,	
			30. Name and address of person who	completed cause of death (I	tem 23a) (Type, Print) 111 Pen	n Stree	t, Balti	more,	Maryla	nd 21201
4	· C.	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig							
t <u>i</u>	Regist			2004	K	Sports					

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			1- State Registrar Unpend It	em#23a,Part II, 27,Per			Reg. N		
	Physici /Medi		1. Decedent's Name (First, Middle Richay	1 / 2 2	Copes	M F	EB. 19	y Year 2004	3. Time of Death
	Examir	ner	4a. Facility Name (If not institution) 811 Phillips		4bJCity, Town, or L CAMBRID		4	c. County of Deeth DORCHES	
317	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year Months Days	If Under 24 Hrs. 8, Da	ate of Birth fonth, Day, Year	9. Birth	place (State or Foreign intry)
M	Director		Usual Residence of Decedent	67	Yrs.	Mo	ireh 29,	1939 MO	iryland
	with the Maryland is or 28a-f ahow Lounvillied at	2	10a. State 10b. County		wn or Location				10d. Inside City Limits 1 ✓ Yes 2 ☐ No
3	r 28a-f	recto	10e. Street and Number	chester (Cambrid 10f. Zip Code	ge	10g. C	itizen of What Cou	
2	be filed within 72 hours after death with the Marylar lat Hygiene. d othar than "natural", or Itams 23s or 28s-f show avent, the Medical Examement must be notified at	Funeral Director	811- Ph:	11:PS Street	210	613		USA	
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0036	ural', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🗹 No	Specify:		Specify: B10	acK
15-6	in 72 t	Completed	15. Decedent (Specify only highes		 Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired) 	ion iring most of working	16b.	Kind of Business/Ir	ndustry
212	filed within 72 hours after Hygiene. ither then "natural", or Its ent, the Medical Exercition	Com	Elementary/Secondary (0-12)		LumberJac			unber C	COMPONY
land		To Be	17. Father's Name (First, Middle, I	Manuel		18. Mother's Name (Firs.	, Middie, Maide	Copes	ζ.
Baltimore, Maryland 21215-0036	d 2 should be th and Menta 7 is markad traumatic av	-	19a. Informant's Name/Relationsh	nip (Type, Print)	b. Mailing Address (Street ar	~ · ^	1 . 1	or Town, State, Zi	
e, Z	s 1 and f Health itam 27 other tr		Daretha 20a. Method of Disposition		of Disposition (Name of	Date	bridge	May 4 I	own, State
Ē	0 0 = 5		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Hemoval from State 4	ery, crematory or other place, hore Cremat				Marylans
Balti	permit. Pag Department Important: any injury c		21. Signature of Funeral Service I	icensee 7	22. Name and Address	of Facility	Me, P.A	" "	
	46244		23a. Parti Enter the disease, or	complications that caused the death. Do only one cause on each line.	510 Wash	NO TOW ST	Camby	idge, M	Approximate
	Physician		Immediate Cause (Final disease or condition	a Hypertensive Ather					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence	roij.		***		
	be executed ician and burial-transil	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	of):				
760,	te be e. ysician ie buria			d					
x 687	eath certificate be executed attending physician and for use as the burial-transit	Medi	IF FEMALE:	020 Huse sutesment accessory			1		
Box	ne death c the attend	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	ery Day Year
P.0	that the died by the detached	Phys	9 ☐ Unknown Part II. Other significant conditio	ns contributing to death but not resulting	in the underlying cause given	in Part I, 2	3e. Did tobacco	use contribute to t	he cause of death?
rds,	w requires that been signed t should be det	ed by	Bronchitis				1 ☐ Yes 2	Prol	bably 4 DUnknown
Division of Vital Records,	e tar has	ompieted					4a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available impletion of cause of
ital		Be Co	25. Was case referred to medical examiner?			26. Place of Death (Che	XYes 2 N	1 Yes	2 L No
of V	S 5	၉	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/O		4 Nursing Home	Residence		M AT SCENE
ion	or Attanding uter death. Director: After in by the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Day Year) Pation	Injury Work?	es 2 No	,	,	
Divis	al or Attand after death Director: , d in by the f	ertification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		arm, street, factory, office	28f. Lc	cation (Street a ty or Town, Stat	nd Number or Rur e)	al Route Number,
_	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	O	29a. Certifier 1 Certifyin	g Physician: To the best of my knowledg Examiner: On the basis of examination a	e, death occurred at the time	, date and place, and du	e to the cause(s	s) and manner as s	tated.
	thin 24 thin 24 tha Fi	Medical	29b. Signature and title of certifier	and manner stated.	29c. License			ate signed (Month,	` '
	5 3 T 8		Dave.	D	O.C.		FE		
			30. Name and address of person of	who completed cause of death (Item 23a)		Daltimos	Marrela	nd 21201	
	Sta	ite	31. Date filed (Month, Park Year)	2 32. Redistrar's Signature	Penn Street,	рат слиоте,	nary	IN SIZUI	
	Regist	rar	FLUA	3 2004 Janes S	- Miller				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Ared egible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Carol Moran Clary February 2004 12:35 p.™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 215-62-2116 Director 50 7, 1954 Maryland Usual Residence of Decedent 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits r then "natural", or itema 23a or 28e-f shov the Medical Exercises or must be notified at 1 Yes 2 □ No Director Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 427 Willis St. 21613 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married 1 ☐ Yes 215 No Baltimore, Maryland 21215-0036 δ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) waitress restaurant 10 Pages 1 and 2 should be filed w thent of Health and Mental Hygies thant: if item 27 is marked other ti jury or other traumatic event, 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Moran Rosalie Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ann Travers sister 6125 Fooks Mill Rd., Rhodesdale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or Dorchester Memorial Park 2/20/04 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Buth Brian K. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small cell Frysician Non APRIL 2003 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): ending physician and r use as the burial-transit or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): IFFEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ 100 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 5 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2-17-2003 D47924

State Registrar

P.O. Box 68760,

Division of Vital Records,

AURORA

2 Degistra Signature

MD 2/6/3

CAMBRIDGE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300

NOMAN THANKY

31. Date filed (Month, Day, Year) B 1 9

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F	Health and M Death		ene 200	4 07523
	Physici /Medi			Mae Cr	oke			2. Date of Death Month February		3. Time of Death 12:49 p.M.
	Examir Funeral	ner	,	sing Center	(In yrs. last birthday,	Le	on Location of Death onardtown If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Y	9. Birt (eer) Co	ary s
6	Director		530-22-6266 Usuel Residence of Decedent 10a. State 10b. County		64 Yrs. 10c. City, Town or L	ocation		Aug. 8,	1939 Ca1	ifornia 10d. Inside City Limits
	vith the Ma or 28s-f s	Director	Maryland St. 10e. Street and Number	Mary's		Leonardt 10f. Zip Code	own	10g	. Citizen of What Co	1 ☐ Yes 2 € No ountry?
5-0036	be filed within 72 hours after death with the Maryland nai Hygiene. od other than "natural", or itams 23e or 28e-f show event, the Modical Examiner must be notified at	by Funeral	40559 Port Pla 11. Marital Status 1 Never Mamed 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ex Armed Forces?			dispanic Origin? (Sp an, Mexican, Puerto		nited Sta 14. Rece - Ame Black, Whit Specify: Wh	nican Indian, e, etc.
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Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be	17. Father's Name (First, Middle, Last James Oliver S 19a. Informant's Name/Relationship	nyder	19h Maili	ng Address /Street	Myrt1e	e (First, Middle, Mae Mae Robe	rtson	Fin Code)
	2 등 등 등 등		Donald R. Crok	e / Husband	40559	Port Pla	ace, Leon	ardtown,		20650
Baltimore,	pernit. Pages 1 a Department of Hea Important: If item any injury or othe once.		*4 □Donation 5 □Other (Spec 21. Signature → Fureral Service Lice Edward N. Brinsi	ensee		2. Name and Addre		insfield		
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C. BOX	at the death certificate by the attending phys tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 PNo 9 □ Unknown	23c. If yes, outcome of 1☐Live birth 2 4☐Pregnant at tir 9☐Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		-	23d. Date of deli-	very Day Year
cords, P	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to 2 □ No 3 Pro	the cause of death?
Vitai Rec	The ate has page	e Completed	25. Was case referred to medical					24a. Was an autopsy performed	prior to c death?	opsy findings available ompletion of cause of
VISION OF VI	Phys this al dii	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		er: 4 Nursing Ho	me 5 Residence 28d. Describe how i		ify)		
DIVIS	i Dir	Certification:	3 Suicide 6 Could not l	building, etc.				28f. Location (Stree City or Town, S	tate)	
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 12) Certifying P 2 Medicel Exa 29b. Signature and title of certifier	Physicial: To the best of eminer: On the basis of example and manner state	xamination and/or in	r occurred at the time restigation, in my op	oinion, death occurr	ed at the time, date	e(s) and manner as and place, and due Date signed (Month)	to the cause(s)
6	P 3 = 8		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	Do	2641	2	2-11-	04
	Sta	60	J. Patrick Jar 31. Date filed (Month Day, Year)	boe, M.D., 2	24035 Thre	,	Road, Hol	lywood, M	aryland 2	0636
A	Registra	ar	FEB 1	2004	per 10° 1					

			1 - For State Registrar	State of Ma	ıryland / Depa <i>Cei</i>	artment of H rtificate of L	ealth and M Death	lental Hygie	ene 2004	07524
	Physici /Medi			Ann Callan	nan			2. Date of Death Month February	Day 16, 2004	3. Time of Death $11:03P^{M}$
	Examir	ner	4a Facility Name (If not institution, give 39595 Ellen Court			Mechanio	Location of Death		4c. County of Death St. Mary	
	Funeral Director		212-00-2713	ex	(In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You June 6, 195	Bar) Cou	place (State or Foreign intry) y Land
	show	2	Usual Residence of Decedent 10a. State 10b. County Marry Land St. Marry	· la	10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the M a or 28a-f be notiff	Director	Maryland St. Mary 10e. Street and Number 39595 Ellen Court		Mechan	10f. Zip Code	559	10g	. Citizen of What Cou	
320	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Madical Examiner main be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	USA 14. Race - Ameri Black, White Specify: Wh:	, etc.
21212-0030	d within 72 hou jiene. r than "natura ins Madical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		F)	dent's Usual Occupa kind of work done of DO NOT use retired, Store Ma		ing 160	b. Kind of Business/Ir	•
yland	uld be filed Mental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) John Briscoe Wat				18. Mother's Name	e (First, Middle, Mai e Martha	den Sumame)	
Mary	nd 2 sho alth and h 27 is ma ir trauma		19a. Informant's Name/Relationship (1888) Bernice Carter/Da						ity or Town, State, Zi	
more,	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Dispo- cemetery, crem Charles Mem	sition (Name of natory or other place	e)	Date 200	Location - City or Tonardtown,	own, State
Dairimo	permit. Departm Importa any inju		21. Signature of Fundan dervice to the	ee men			s of Facility Matt	ingley-Gard	iner Funeral town, MD 206	Home, P.A.
6 .	Calle be executed /Medical Examiner the burial-transit the burial-transit	dicai Examiner	23a. Part . Enter the disease, or companies, or heart failure. List only of the second state of the second	b. Due to (or as a	consequence of): consequence of):	11	atom			Interval Between Onset and Death 22 mmy44
O. BOX O		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
cords, r	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death but	t not resulting in the un	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ם שבנים	n: The law re- icate has bee r, page 2 sho	Completed						24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of
I A I O II O II	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after defore; the theore after defore the completely filled in by the funeral director, page 2 should be detached for use as	ation; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	t 2 ER/Outpatient	28c. Injury Work	26. Place of Death 4 Nursing Hor at 7 es 2 No		e 6 Other (Specification)	5 y)
	ital or Atte	Certification;	3 Suicide 6 Could not be determined	building, etc.				City or Town, S		
	the Hosp ain 24 hou the Fune apietely fill	Aedicai	one)	ysician: To the best of niner: On the basis of e and manner state	examination and/or inv	restigation, in my op	inion, death occurre	ed at the time, date	and place, and due to	o the cause(s)
	Ton	2	29b. Signature and title of certifier	Anty		29c. License			Date signed (Month,	*
10	3/		30. Name and a ress of person who o	HORTON	ath (Item 23a) (Type, F	Print) 2500 Po	ort Locke	VT Pa Le	2/17/04 Co Box 5	27/10/10
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar	S Signature	And the			ZC	16 5C

State of Maryland / Department of Health and Mental Hygiene $200 \, \mu$ 07525 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nancy Lee Cleare 19, 2004 4c. County of Death /Medical February 4:004a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lothian Under 1 Year 106 Mary Lou Drive <u> Anne Arundel County</u> If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 💢 F Hours 56 Director 365-48-1869 June 10, 1947 Ohio Usual Residence of Decedent 10c. City, Town or Location 10a. State work 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner mant be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Co. Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 Mary Lou Drive 20711 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 21 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Commercial Refrigeration Co. Self-Employed permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward L. DeForest Mary Yager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin H. Shepherd (Fiance) 106 Mary Lou Drive, Lothian, Maryland 20711 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 XBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Southern Mem. Gardens 23, 2004 Dunkirk, Maryland 21. Signature of Fundal Service Licen 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. apenael W. Lee 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast **Physician** Cancer Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Physician/Medical Examiner sician and burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. the use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes .2 No į Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been signated bage 2 should b 1 Tyes 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗘 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 X No Certification: To 4☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time_date and place, and due to the cause s and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52830 Klimne Weng, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Lied #300 Annapo eanine Werner 900 MD32. Registr Signature 31. Date filed (Month, Day, Year) State FEB 2 3 2004 Registrar

			1 - For State Registrar 1. Decedent's Name (First, Middle, Las	State of Maryla		artment of I rtificate of			Reg. No. 200	4 07521	
	Physici /Medio	al	Bessie 4a. Facility Name (If not institution, give	Viola	(Carbaugh	or Location of Dea	Februs Februs	Day Year	104 0650 M	
	Examir	er	Washington Count			Hagerst		uı	Washingt		
	Funeral Director		5. Social Security Number 6. S 214-10-1166	<u> </u>	s. last birthday) Yrs.	If Under 1 Year Months Days			9. Bi 1904 Mar	rthplace (State or Foreign country) yland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or itams 23e or 28e-f ehow enty injury or other traumatic event, it a Mudical Erani at must be notified at ance.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Washingt 10e. Street and Number 20630 Emerald Dr. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest gra Elementary/Secondary (0·12) 0 17. Father's Name (First, Middle, Last) Harry W. Nogle 19a. Informant's Name/Relationship (1) Wayne L. Carbaugh 20a. Method of Disposition 1 Donation 5 Other (Specify 21. Signature of Funeral Septice Licen	On Ha	16a. Dece (Give life) Homen 19b. Maili 20630 Place of Dispocemetery, cre-	WIN 10f. Zip Code 21740 Was Decedent of It If Yes, specify Cub 1 Yes 2 No dent's Usual Occup kind of work done DO NOT use retire naker	Specify: pation during most of word 18. Mother's Na Bertie and Number or R Dr. Hag ce) ry 2/24	Specify Yes or No- to Rican, etc.) wrking me (First, Middle, ROSe11a; ural Route Numbe erstown, Date / 2004	Specify: White 16b. Kind of Business/Industry Own Home a, Maiden Sumame) Six Der, City or Town, State, Zip Code) MD 21740 20c. Location - City or Town, State Hagerstown, MD		
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Vital	Physician: The this certificate I ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: ./		10		ath (Check only or			
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	To t To t	Ž	29b. Signature and title of certifier			29c. Licens		. 2	9d. Date signed (Mon		
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			1 - For State Registrar	State of Mai	-	partmei e <i>rtifica</i>			d Ment		jiene 1eg. No. 20	NL	07527
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	Examir Funeral		4a. Fecility Name (If not institution, give s FANTALY - Keed 5. Social Security Number 6. Sex	NUrsin	19 Home	ay) If Under	ONS or 1 Year	Short If Under 24 Hours	Death Hrs. 8 D	ate of Birth	4c. County	9. Birthol	ngton ace (State or Foreign ty)
	Director		217–32–8129 Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or				Ju	Ly 26	, 1908		7 Land Od. Inside City Limits
	death with the Maryland ms 23a or 28a-f ahow	ector	Maryland Washingto	i	Boonsb	oro	p Code			1	0g. Citizen of W		1 ☐ Yes 2√∏No
	sath with	erai Dir	8705 Mapleville Ro	ad			2	1713	0 /0		U.S.A.	'	
		by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marned 3 △ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 점 No If Yes, Give Year or Dates:	er in 0.5.	If Yes, spe		ispanic Origin n, Mexican, P Specify:	r (Specify 1 ruerto Rican	, etc.)	Black	- America c, White, e whi	etc.
(R	within 72 hours after ene. than "natural", or ite ta Medical Erasi or	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 0-12	cation completed) College (1-4or 5+)	(G	cedent's Usive kind of web. DO NOT i	ork done d ise retired	ation during most of	working		16b. Kind of Bu	siness/Ind	
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	d 2 should th and Men 27 Is marke traumatic	To	19a. Informant's Name/Relationship (Type Grace Gue - niece						r Rurai Rou	te Number	, City or Town, S	State, Zip	
V O	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Dis	sposition (Na	me of	a)	bruary 25,200		20c. Location - (City or Tov	vn, State
Baltii	Departm Departm Importar any inju		21. Signature of Funeral Service License	e li		22. Name a	nd Addres	s of Facility	Minn	ich l	Funeral	Home	
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rds, P.	w requires that I been signed by should be deta	by	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying	cause give	en in Part I.	_ 2				cause of death?
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SH	18		30. Name and address of person who con	mpleted cause of deal	th (Item 23a) (Typ	4 44	:PAL	urg , 191	D 26	-1.5.			
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			1 - For State Registrar	State of Maryland / Depa		Mental Hygie	
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
	/Media	al	Robert Alan Cle 4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Deat	tebrung	4c. County of Death
	Examir	er	Washington County		Hagerstown	,	Washington
ī	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day,) April 13	
ei .	Director		032-28-5241 XXX	M 2□F 65 Yrs.	Months Bays Hours Min.	April 13	,1938 Massachusetts
	yland Now		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	a-fat	ctor	Maryland Washin	gton W	illiamsport		1 □ Yes 🛣 No
	death with the Maryland ms 23s or 28s-f show frods be notified at	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Country?
	ath w	rai	16614 Hawks Land		21795		USA
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21215-0036	be filed within 72 hours after death with the Marylan hal Hygiene. of other then "natural", or leams 23s or 28s-f show event. The Michael Extendible must be notified at		3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: White
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an	lid be lental ked o lic eve	To Be	Rufus Cleveland		Dorothy		,
Maryland	should and Mer a marke umatic	-	19a. Informant's Name/Relationship (Typ	pe, Print) 19b. Mailir	ng Address (Street and Number or Ru		City or Town, State, Zip Code)
	s 1 and 2 should f Health and Mer flem 27 is marke other traumatic		Carol Cleveland -		4 Hawks Landing L		amsport,MD 21795
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Dispo cometery, crea	osition (Name of matory or other place)	Date 20	c. Location - City or Town, State
ij			*4 Donation 5 Other (Specify)	Manningto			annington West Virginia
Bal	permit. Deportrimports any nju		21. Signature of Funeral Service Livens	1. 2.1/	Soonae Attonerativ Ho	•	1: MD 01705
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Л	Physician		Immediate Cause (Final	1			Onset and Death
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Re	o - &	mo m				autopsy performe 1 Yes 2	prior to completion of cause of death? No 1 □ Yes 2 No
of Vital	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical		26. Place of Dea	th (Check only one)	110 4210
× <		To	T Tes ZA No	ospital: 1 Inpatient 2 ER/Outpatier		ome 5 Residenc	ce 6 Other (Specify)
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Β̈́	after after Direct	Certification:	4 Homicide determined	building, etc. (Specify)	oot, ractory, office	City or Town,	
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di		29a. Certifier Certifying Phys	ician: To the best of my knowledge, death	h occurred at the time, date and place	, and due to the caus	se(s) and manner as stated.
	he Ho in 24 he Fu pletel	edical	(Check only one) Medical Examin	er: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
	To the I within 2 To the Complet	Σ	29b. Signature and title of certifier	A - A NATO	29c. License number	290	. Date signed (Month, Day, Year)
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1	#-4		30. Name and address of person who con	inpleted cause of death (Item 23a) (Type	a Surk 150	Hage	15+15 CM NWOFER
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	Registr		FEB 18 200	14 Dusum B. St.	ads)		

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/Medic			Marg	garet Cr	eegan					all are	16	04	7:23 AM
xamin	er	4a. Facility Name (If not institution, g	rt Hosi	4			mb, or	Erlan	- 1		4c. County	of Death	1 \ /
neral		5. Social Security Number 6	. Sex 7.		last birthday)	If Unde	r 1 Year	If Under 24 h	ırs.	B. Date of Birth			
ector		213-40-3711	1□M 25XF	62	Yrs.	Months	Days	Hours N	lin.	(Month, Day, Y February (e <i>ar)</i> 05, 1942	Coui	Maryland
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in tem 27 is marked other than institral, of tems 23s of 28si-shot or other traumatic event, the Medical Examinar must be multified at	Funeral	11. Marital Status	12. Was Decede	s?	J.S. 13. \	Vas Dece Yes, spe	dent of Hi cify Cuba	spanic Origin? n, Mexican, Pu	(Spec	ify Yes or No- ican, etc.)		e - Americ ck, White,	ean Indian, etc.
o in	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			I □ Yes	2 No	Specify:			Specif	y:	White
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is marked other than aumatic event, the My	۲	19a. Informant's Name/Relationship			19b. Mailin	g Address	(Street a	and Number or	Rurai	Route Number, C			Code)
othar tra		Paul Creeg	gan-Husband				Ş	Boone S	treet	, Cumberlar	nd,Md. 2	21502	
or oth		20a. Method of Disposition 1	☐Removal from Sta		cemetery, cren	natory or o	other place	·			c. Location -	City or To	wn, State
	r												
any injury once.		21. Signature of Funeral Service Lig	ensee		22	. Name ai	Addres Eic			zie Funeral l maconing, N			. Main
dical dical niner transit the private and the	Exa	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consection as a consection	quence of):	MAN	,	8	ti	olon			340
hed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outco 1 □Live birth 4 □ Pregnan 9 □ Unknown	tattime of d	al death 3	Ectopic pi Other <i>(sp</i>			-		23d. Dai Mo	le of delive	ry Day Year
> ms	ρ	Part II. Dther significant conditions	contributing to deat	h but not res	sulting in the ur	derlying o	ause give	n in Part I.			AL.		e cause of death? ably 4 □Unknown
id be detac	olete								- Y	24a. Was an autopsy		prior to con	osy findings available npletion of cause of
should be	Ē									performed 1 ☐ Yes 2 🔀		death?	2 □ No
should be	Completed		25. Was case referred to medical examiner?							Check only one)			
should be	Be	examiner?	Hospital:	ationt 2	ED/Outpation		2A	4 Nursing		5 Residence d. Describe how i			")
should be	To Be	examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of I	njury	28b. Time of			at	28	d. Describe now	illary occur	90	
ed bluods	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of I				8c. Injury Work	at ? ∕es 2 □ No	28	d. Describe now i	injury occurr	90	
should be	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	M	8c. Injury Work 1 🗆 Y			f. Location (Stree City or Town, S	t and Numb		Route Number,
should be	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 2 Accident investigat 3 Suicide 6 Could not determine 4 Homicide 1 Certifying	28a. Place of land (Month, lon be land 28e. Place of building, Physician: To the beauting: On the pass	Injury - At hetc. (Speci	28b. Time of Injury ome, farm, stre	M eet, factor	28c. Injury Work 1 □ Y y, office	res 2 □ No	28	f. Location (Stree City or Town, S	t and Numb tate)	er or Rura.	ated
should be	ledical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only 2 Wagucat Ex	28a. Place of building.	Injury - At hetc. (Speci	28b. Time of Injury ome, farm, stre	M aet, factor	28c. Injury Work 1 □ Y y, office	e, date and pla	28	f. Location (Stree City or Town, S d due to the caus at the time, date	t and Numb tate)	er or Rura nner as st and due to	ated. the cause(s)
of the related brecon. Alter this completely filled in by the funeral director, page 2 should be	ledical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) Wearusa Exp	28a. Place of land (Month, lon be land 28e. Place of building, Physician: To the beauting: On the pass	Injury - At hetc. (Speci	28b. Time of Injury ome, farm, stre	M aet, factor	28c. Injury Work 1 TY Y, office at the time, in my op	e, date and pla	28	f. Location (Stree City or Town, S d due to the caus at the time, date	t and Numb tate) e(s) and ma and place, a	er or Rura nner as st and due to	ated. the cause(s)
should be	ledical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) Wearusa Exp	28a. Place of I (Month, lon be add 28e. Place of building, Physician: To the beautiner: On the pass and manner	Injury - At hetc. (Special of death (Itel)	28b. Time of Injury ome, farm, stre	M occurred estigation 290	8c. Injury Work 1 Y office	e, date and pla	28	f. Location (Stree City or Town, S d due to the caus at the time, date	t and Numb tate) e(s) and ma and place, a	er or Rura.	ated. the cause(s)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001

				Certificate of	Death	Reg. No.	
	Physicia: /Medica		Last) EANORA CULP		2. Date of Month	of Death Day	Year 3:40 PM
	Examine	4a Facility Name (If not institution,	give street and number) NURSING HOME		4b. City, Town, or Location of I	Death 4c. County of	
	Funeral Director	5. Social Security Number 577-34-3622 Usual Residence of Decedent	5. Sex 7. Age (In yrs. 1 M 2 F 88	. last birthday) If Under 1 Year Months Days	Hours Min. (Monti	of Birth h, Day, Year) 8,1915	Birthplace (State or Foreign Country) MARYLAND
	the Meryland 28a-f show	10a. State 10b. County WW MINE 10e. Street and Number	-	ity, Town or Location RIDGELEY		10- Cisi (W	10d. Inside City Limits 1 ☐ Yes 2 XNo
	23e or	ROUTE 2, BOX 20	2	26753		10g. Citizen of W	
0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Expriner must be notified at once, and in the Medical Expriner must be notified at once.	3 XWidowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? d 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates:	J,S. 13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Specify Yes of an, Mexican, Puerto Rican, etc Specify:		- American Indian, c, White, etc. WHITE
21215-0020	led within 72 hoi ygiene. her than "netura it, the Medical E	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire ASSEMBLER	during most of working	16b. Kind of Bus	
Maryland 2	Mentel Hyg Mentel Hyg arked other aftc event,	17. Father's Name (First, Middle, Li	,		18. Mother's Name (First, Mi)
, Mar	end 2 sho ealth and I n 27 is me her traume	19a. Informant's Name/Relationshi	/ SON	ROUTE 2, BOX	t and Number or Rural Route N 202, RIDGELEY		_
Baltimore,	. Pages 1 tment of H tant: If iter jury or oth	20a. Method of Disposition 1	☐Removal from State FOR	Place of Disposition (Name of cometery, crematory or other place of LINCOLN CEME		l.	OOD, MD
Bai	permit Depar Impor any in	21. Signature of Funeral Service Li	logcheuch)		FUNERAL HOME, E STREET, CUMB		21502
	Physician	23a. Part1. Enter the disease, or conshock, or heart failure. List or	om lications that caused the deat ly one cause on each line.	th. Do not enter the mode of dy	ng, such as cardiac or respirato	ry arrest,	Approximate Interval Between Onset and Death
A	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Renal	or as e consequence of):	anoms		2 years
	executed in end iel-transit		b		= -		
68760,			c	or as a consequence of):			
	certificate be nding physicia use as the bui		Due to (o	r as a consequence of):			
ň	death e etter d for u	Part II. Other significant conditions	contributing to death but not rec	ulting in the underlying eques of	yon in Port I 22h	Did tabasa was sant	ibute to the course of death?
, О	that the death led by the etter deteched for a	Coronary					ribute to the cause of death?
vital Records,	The law requires that the death site bas been signed by the etter page 2 should be deteched for the completed by Physician	Remi	Farlure		24a. V	Vas an autopsy erformed?	24b. Were autopsy findings available prior to completion of cause of death?
					1	☐ Yes 2 No	1 ☐ Yes 2 ☐ No
<u> </u>	clan: eartific ector		Hoopital.	100	26. Place of Death (Check or	nly one)	
5	Attending Physician: or death. betor: After this certific by the funeral director, iffication: To Be (28a. Date of Injury (Month, Day Year)	28b. Time of Injury Wor	y at 28d. Descr Yes 2 □ No	lesidence 6 Other	
DIVISION	~ = 0 D -=	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Injury - At ho building, efc. (Specify	ome, farm, street, factory, office	28f. Locatio City or	on (Street and Number Town, State)	or Rural Route Number,
	To the Hospital or within 24 hours effe To the Funerel Dir completely filled in Medical Cert		Physician: To the best of my known aminer: On the basis of examinat and manner stated.	wledge, death occurred at the tir tion and/or investigation, in my o	ne, date and place, and due to pinion, death occurred at the tir	the cause(s) and manner, date and place, an	ner as stated. d due to the cause(s)
i	within some	29b. Signature and title of certifier	5	e number	29d. Date signed (
	n (0	30, Name and address of person wh	o completed cause of death (Item	-1249		12004	
7	125	Jesus Tan, M:	D Frostburg	Plaza, Fro	stburg, MD	21532	
	State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture & Angel	,		

			For State Registrar		State of M	•	-	tment of H ificate of i				giene Reg. No.	2004	. 07531
	Physici			e (First, Middle, La Dir ley		care	7				2. Date of Dea Month	Day	Th Year	3. Time of Death
	/Medi Examir		4a. Facility Name (I	If not institution, giv	e street and number)	neral 1	tosp	4b. City, Town, or		of Death	en	4c. C	ounty of Death	~
	Funeral Director		5. Social Security N	-1188	ex 7. Ag	ge (In yrs. last bir 77		If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Birti (Month, Day 'eb. 2 ,	v, Year)	Co	hplace (State or Foreign untry) aryland
	aryland show	_	Usual Residence of	10b. County	Coorgon	10c. City, Tow		ition						10d. Inside City Limits 1 □ Yes 2 □ No
	ith with the Maryland 23e or 28a-f show ust be notified at	Director	MD 10e. Street and Nu	<u> </u>	Georges	LAU	KEL	10f. Zip Code				10g. Citize	en of What Co	
	€ 8 4	aiD	614 1	10th Str	eet			20	707			Ι τ	J.S.A.	
36	or Items	by Funerai	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 2⊠ Married 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes XX If Yes, Give Year or Dates:	,	1	as Decedent of H res, specify Cuba	lispanic Or an, Mexical Specify:		ify Yes or No- ican, etc.)		Race - Ame Black, White pecify:	
21215-0036	nin 72 hours J. In "naturel", Medical Ex.	Completed	(Spec	15. Decedent's E			Deceder (Give kil	nt's Usual Occup nd of work done of NOT use retired	ation during mos d)	at of workin	g		of Business/	
21,	giene giene er the	ĕ	12th	1			Foo	Proce					inary	,
pu	be filed Ital Hyg od other	Be		(First, Middle, Last,							(First, Middle,			
Z Zaa	narke	၉		Jackso		10h	Mailina	Address (Street			e Mit			Zin Codel
Maryland	s 1 and 2 should f Health and Men item 27 Is marke other traumatic			ame/Relationship (Johnson	Daughte		•	N. Cha						
Baltimore,	00-		20a. Method of Dis 1 XBurial 2	position	Removal from State	20b. Place of cemeter	Disposit ry, crema	ion (Name of tory or other plac	(e)	Da	te	20c. Loca	ation - City or	Town, State
Baltir	permit. Page Department of Important: If eny injury or once.	MD National Cem 2/23/2004 Lau: 1												ome, P.A.
	Pnysician /Medical Examiner		shock, or hea Immediate Cause disease or condition resulting in death)	art Yaflure. List only (Final on	plications that cause one cause on each li a. Due to (or as	d the death. Donine.		the mode of dying ytthrough car			respiratory an	rest,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list co any scale in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	erlying r injury	c	a consequence	ver	rains	sir	no.	ndso	IIS		
P.O. Box 6	requires that the death certificen signed by the attending I hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetel death		ctopic pregnancy Other (specify)				23	d. Date of deli Month	very Day Year
	quires that n signed by	by	Part II. Other signi	ficant conditions	contributing to death b	out not resulting in			en in Part I	Leed	23e. Did to	1.00		the cause of death?
Division of Vital Records,	The law ate has b page 2 sl	Completed		•							24a. Was a autop perfor 1 Yes	an sy med? 2 No	24b. Were au prior to d death? 1 🗆 Yes	topsy findings available completion of cause of 2 No
/ita	Physicien: The this certificate al director, pag	Be	25. Was case reference examiner?		Hospital:			3CI DOA Oth	00	S-10-10	Check only or			
on of	ng Phys tter this neral dii	ion; To	1 Yes 2 2 27. Manner of Deat		28a. Date of Inju (Month, Da	/rv 28b. 1	tpatient Time of njury	28c. Injur	4 🗆 140	28	e 5 Resid			ify)
Divisio	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	e 28e. Place of Inj	jury - At home, fa c. <i>(Specify)</i>	rm, stree				3f. Location (S City or Tow		Number or Ru	ral Route Number,
	Hospitel 24 hours Funerel etely filled	Medicai C	29a. Certifier (Check only one)		nysicien: To the best niner: On the basis o and manner st	f examination an	d/or inve	stigation in my o	pinion, dea	th occurre	d at the time, o	tate and o	lace, and due	to the cause(s)
	vithin To the compl	Me	29b. Signature and	title of certifier)			29c. Licens	e number		2	29d. Date	signed (Month	n, Day, Year)
	70		30 Namo and add	Jes of parent who	completed cause of o	death (Item 23a)	(Type Pr	D	508	70	7 A	COIN	my 20	0 2004
			30. Name and additional state of the state o	n Abd	0 5005	rar's Signature	na	l'Bell	las	re C	lack	sul	ce M.	Day, Year) Description of the second of the
	Sta Regist			EB 24 2	004 Se	rar's Signature	9	spark	2					

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan	nd / Depa	artme		alth and I	Mental Hy	giene	•	07532
	Physici		Decedent's Name (First, Middle, La ANITA CHANG	st)					2. Date of Dea Month Februa	Day	16, 2004	3. Time of Death 5:45 PM
	/Medic Examin		4a. Fecility Name (If not institution, given Casey House, Mo		ce		, Town, or L	ocation of Death		4c.	County of Death	1
	Funeral Director		5. Social Security Number 6. S 216–40–7027			If Und Month		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct. 24		9. Birth	nplace (State or Foreign intry) 11na
	Maryland 8-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom		ty, Town or Lo		g					10d. Inside City Limits 1 Tyes 2 □ No
	th with the 23e or 28	ai Dire	10e. Street and Number 15200 Middlegate	Road			ip Code :0905			10g. Citi	en of What Cou	untry?
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23e or 28a-f ehow event, I're Medical Examinat mast be mullified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 22%No II Yes, Give Year or Dates:			edent of Hisp ecify Cuban, 2 2 No		pecify Yes or No- o Rican, etc.)		14. Race - Amer Black, White Specify: AS	, etc.
Maryland 21215-0036	within 72 ho one. then "naturi	mpieted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+) 2 Years	(Give	kind of v	use retired)	on ring most of wor	king		nd of Business/l	-
land 2	I Hygir other	To Be Co	17. Father's Name (First, Middle, Last Chang Tso Li)	110	Jiieni			ne (First, Middle, tainable	Middle, Maiden Surname)		
	and 2 should and North and		19a. Informant's Name/Relationship	nakis/Daughter	1520	oim C	ld1ega	te Road	-	Spr	ing, Ma	ryland 2090
Baltimore,	Chang Tso Lin Chang Tso Lin (Unobtaina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route No. 19										cation - City or 1	ng, Marylar
Ba	Depril		Nancey A. Lecante HINES-RINALDI FUNERAL HOM 11800 New Hampshire Avenue									20904 ring, MD Approximate
	Physician /Medical Examiner		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Debility Due to (or as a consequence of): Cerebrovascular Disease									Interval Between Onset and Death Months 1ess 1 year
68760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect d. Due to (or as a consect d.								
O. Box	that the death certificate I hed by the attending physic detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnation in Live birth 2 Feta 4 Pregnant at time of c	al death 3	⊒Ectopic ⊒ Other (pregnancy specify)			2	23d. Date of delin Month	very Day Year
rds, P.	The law requires that the ate has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions Pneumonia	contributing to death but not res	sulting in the u	inderlying	cause given	in Part I.		bacco u es 2		the cause of death?
al Records,	U 25. Was case referred to medical examiner? Hospital: Other									24b. Were aut prior to co death?	opsy findings available ompletion of cause of 2 No	
Vital										_	T1	
of	ding Phys h. After this funeral di	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury a Work?	4 Nuising I	ome 5 ☐ Resid 28d. Describe h			h)Hospice
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not I 4 Homicide determined	De 29a Blace of laive. At h	ome, farm, st	reet, facto			28f. Location (S City or Tow			al Route Number,
	he Hospi in 24 hou he Funer pletely filt	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurre vestigation	d at the time on, in my opin	, date and place non, death occu	, and due to the or rred at the time, o	ause(s) date and	and manner as place, and due	stated. to the cause(s)
)	To the state of th	2	29b. Signature and this of confiler	fer-		2	9c. License i	oumber 5412.		29d. Date	signed (Manth) $16/0$, Day, Year)
	V		30. Name and address of person who Charles Harris							, Ma	ryland	1
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature &	de	racks	,				

DHMH 17 Rev 1/2001

Anita Chang

		,	For State	State of	Maryland / De	partme <i>ertifica</i>			and Me		giene Reg. No	2001	07500
			Registrar 1. Decedent's Neme (First, Middle, L.	ast)		Crimoa	10 07 1	- Journ		2. Date of De	ath		3. Time of Death
	Physici	an								Month	Day		3 · 30 P M
	/Medic Examin		Aileen Arnott Cl		er)	4b. Cit	, Town, or	Location o		rebrua		8,2004 County of Deet	
	LAGITIII	161	Laurel Regional	Hospital		Lau	rol				Dr	ince Ge	orași.
3 . 4 7 .0	Funeral	. 7	5. Sociel Security Number 6.	Sex 7.	Age (In yrs. last birthd		r 1 Year	If Under 2	24 Hrs.	8. Dete of Birt (Month, De	th	9. Birtl	hplece (State or Foreign
	Director		577-30-9405	1□ M 2[X]F	86Yrs	Months	Days	Hours		Oct.10			ginia
	P >		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town o	Logation							10d. Inside City Limits
	show	70	Toa. State		Toc. City, Town O	Location							1 ☐ Yes 2 ☐ No
	Sa-f	Director	Maryland Montgor	nery	Burt	nsvil	1e ip Code				10- 03	izen of Whal Co	
	P o a		10e. Street and Number			101. 2					log. Cit	12911 OI WIIAI CO	unity !
	18 23	eral	3415 Greencastle	Road 12. Was Decede	ent Ever in U.S.	3 Was Dec	2086	-, -, -	nin? (Spec	city Yes or No		ISA 14. Rece - Ame	ncan Indian
	Item Item	Funeral	1 Never Married 2 Married	Armed Force	es?	If Yes, sp	ecify Cuba	n, Mexican	, Puerto R	lican, etc.)		Black, White	
336	urs af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1 🗆 Yes	2 ₩ No	Specify:				Specify: Whi	tο
21215-0036	within 72 hours after deeth with the Maryland ane. than 'naturel', or Items 23e or 28e-f show he Micclest Exertines frost be notified at	ted	15. Decedent's 8		16a. De	cedent's Us	ual Occup	ation	t of complete		16b. K	ind of Business/	
218	e. en "o	Completed	(Specify only highest gi	College (1-4	or 5+)	ive kind of w a. DO NOT	use retired)	O WOIKIN	9			
21	gien er th	Con		2		Homema	ker					wn Home	
pu	be filed within 72 hours after deeth with the Maryla stal Hygiene. ed other than "naturat", or Items 23a or 28s-1 show event, the Medical Exercities trust be notified at	Be	17. Father's Name (First, Middle, Las	it)				18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
yla	2 should be filed within and Mental Hygiene. Is marked other then surnatic event, the Ma	ျ	Crockett Brook							Pugh			
Maryland	uses 1 and 2 should nt of Health and Men i. If Itam 27 Is marke or other traumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Addre	s (Street a	and Numbe	r or Rural	Route Number	er, City o	r Town, State, Z	lip Code)
-	1 and Health Iam 27		Margaret Susan Cl	nesney Da	ughter 766	L Wood	park	Lane	_Col	umbia,	Mar	yland 2	1046
0	Pages Inent of H		1 Burial 2 Cremation 3		cemetery (rematory or	other plac	θ)	50	,	200. LC	ocation • City of	TOWN, State
Baltimore,	Party		`4 □Donation 5 □Other (Spec		TOTE BI	Cem	etery	Fe Facility		2004	Bren	twood,M	aryland
Bal	permit. Departr Importa any infe		21. Signature of Funeral Service Lice	1	-	ranci	ș J.	Çoll <u>i</u>	, ins F	uneral	Hom	e, Inc.	,MD 20901
			23a Pert 1 Enter the osease or cor	molications that cau	sed the death. Do not	enter the mo	ivers	o such as	cardiac or	respiratory at	<u>lver</u>	Spring	MD 20901 Approximate
Æ			23a. Pert1. Enter the disease, or conshock, or heart failure. List ont immediate Cause (Final	y one cause on eac	h line.			3,		,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Sepsis	as a consequence of):								l week
	Examiner												0
55°		ler	Sequentially list conditions, if any, leeding to immediate	b. Dement Due to (or	as a consequence of):								2 years
	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	C									
o,	en an rial-tu	EX	resulting in death) Last	Due to (or	as a consequence of):								
8760,	requires that the death certificate be executed seen signed by the attending physicien and hould be detached for use as the burial-transit	dical		d						-			
9	ng ph ng ph s as th	Med	IF FEMALE:										
Box	death certific a attending pl d for use as t	an/l	23b. Was decedent pregnant in the past 12 months?	1 Live birt		3 □Ectopic					i	23d. Date of deli Month	very Day Year
0.	the a	Physiclan/Me	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4□Pregnar 9□ Unknow		5 Other (ipecify)						
Ρ.	that the de ed by the detached		Part II. Other significent conditions	contributing to dea	th but not resulting in th	a underlying	cause divi	en in Part I		23e. Did to	obacco i	use contribute to	the cause of death?
Records,	ires tha signed d be det	1 by	•			,	g				Yes 2		obably 4 Unknown
Ö	w requir been si should	ete								24a. Was		245 Wass ou	tease findings available
Rec	e s c	Completed				-				autop		prior to death?	lopsy findings available completion of cause of
a	ilcian: Th certificate rector, pag	e Co	25. Was case referred to medical					00 DI	10. 1	1 Yes	280 No	1 🗆 Yes	2 ∑ No
Vital	Physician: this certific ral director,	To Be	examiner?	Hospital:	patient 2 ER/Outpa	tient 3 0	Oth	ar		(Check only o		6 □Other (Spec	n fiel
of	Phys er this eral di		27. Manner of Death	28a. Date of	Injury 28b. Tim	e of	28c. Injun	at at		8d. Describe			3177
ion	Attending I r death. ector: After by the funer	atlo	1 XNatural 5 Pending 2 Accident investigati		Day Year) Inju	У	Worl	Yes 2 🗆 N	No				
Division	or Attendate death Director: In by the	iffe	3 ☐ Suicide 6 ☐ Could not determine	200. Place 0	f Injury - Al home, farm, , etc. (Specify)	street, facto	ry, office		21	8f. Location (5 City or Tox	Street an	d Number or Ru	ral Route Number,
	tal or Al s after of al Direct ed in by	Certification:		021101119	, 516. (5,555.)							,	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical			est of my knowledge, d								
	To the h within 24 To the F complete	Medi	one)	and manne									
	To To	-	29b. Signature and title of certifier	IA.		2	ec. License	, Henringi			zou. Da	te signed (Month	, way, radij
	3		fair W				D 4	3237			Febr	uary 20	2004
			30. Name and address of person wh		, , , , , , ,			u					
	CA	ata.	Paul Armstrong,		201 Laure1	Park	Drive	#102	Laı	urel,Ma	ary1	and 20	707
4	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 3 2	004	neva B	de	acks						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 07534 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Vasr **Physician** Ам Yu-Tsin Chou February 18, 2004 1:00 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Manor Care-Bethesda 8. Date of Birth (Month, Day, Y Aug. 5, ff Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 ☑ M 2 ☐ F **Funeral** Months 1915 China 577-04-9117 Director 88 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28e-f showerly injury of other traumatic event, its Madical Exertine fraul for notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10260 Arizona Circle 20817 China Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Asian Ρ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Ching-Chu Chou Not Available Hsu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 McCormick Court, Rockville, Stephen Chou/Son Maryland 20850 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Gate of Heaven February 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donetion 5 ☐ Other (Specify) 2004 Silver Spring, Maryland Cemetery 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West 1 Rockville, Maryland 20850 21. Signature of Funeral Service Licensee Pumphrey Funeral Home/ Montgomery Avenue M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Colon Cancer /Medical resulting in death) Due to (or as a consequence of) Examiner Examiner the attending physicien and thed for use as the burial-transit Physician/Medical page 2 should be detached for Be Completed by

the Hospitet or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, certificate has funeral director, After this hours after death unerel Director: filled in by the within 24 hours a

Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Bladder Cancer Due to (or as a consequence of): c. Atrial Fibrillation Due to (or as a consequence of): d							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23d. Date of delivery Month Day Year							
Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 239. Did tobacco use contribute to the cause of death?								
Hypertension 1 □ Yes 2 ☒ No 3 □ Probably 4 □ Unknow								
Bladder Fistula	24a. Was an autopsy findings available prior to completion of cause of death? □ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? □ Yes 2 ☒ No							
25. Was case referred to medical examiner?	26. Place of Death (Chi	eck anly one)						
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🖾 Nursing Home	me 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Death 1 🖾 Natural 5 🗆 Pending 2 🗀 Accident investigation	(Month, Day Year) Injury Work? M 1 Yes 2 No	Describe how injury occurred						
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one)	ysician: To the best of my knowledge, death occurred at the time, date and place, and d niner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)						

29c. License number

29d. Date signed (Month, Day, Year)

BIVI, BUTINA, MD 20817.

State Registrar

Certification; To

ical

29b. Signature a

30. Name and address of

person who completed dause of death (Item 23a) (Type, Print)

320

32. Registrar's Signature Ryena

			State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.							
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic		Adelaide R. Cohen				February	7 18, 2004		
	Examin		4a. Fecility Name (If not institution, give street and number	er)	4b. City, Town, or	Location of Death		4c. County of Death	1	
			Shady Grove Adventist Hos		Rocks	rille If Under 24 Hrs.	8. Date of Birth	Montgome	TY nplace (State or Foreign	
	Funeral		1 M 2 M E	Age (In yrs. last birthday) 84 Yrs.	Months Days	Hours Min.	(Month, Day, Y	(ear) (ear) New	untry)	
	Director		063-07-1776 Usual Residence of Decedent				NOV. 12,	1919 New	TOLK	
	/land		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
	Man a-f sh	to	Maryland Montgomery	Montgo	mery Vill	age			1 ☐ Yes 2 XNo	
	h the	irec	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	untry?	
	23a C	Funeral Director	19310 Club House Road; #2		2087			Inited Sta		
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show disal Examinational be inclified at	ne	11. Marital Status 12. Was Decede Armed Force	s?	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sr n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White		
36	or It	by Ft	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Date		1 ☐ Yes 2X No	Specify:		Specify: C	aucasian	
Maryland 21215-0036	tural'	d be	3 X Widowed 4 □ Divorced Year or Date 15. Decedent's Education	16a Decer	dent's Usual Occupa	ation	16	bb. Kind of Business/	Industry	
<u>.</u>	in 72	Completed	(Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	luring most of worl	king			
12	with iene.	шо	Elementary/Secondary (0-12) College (1-4)		unch Oper	ator		Paper Ind	ustry	
D	Hyg other	0	17. Father's Name (First, Middle, Last)				ne (First, Middle, Ma	iden Sumame)		
lan	lenta lenta rked ric ev	To B	Harry Reichbach			Annette	Shapiro			
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Unportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or puber traumatic event, the Medical Examination and Dece.		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	rai Route Number, C	City or Town, State, 2	(ip Code)	
Σ	and 2 salth a n 27 i		Phyllis Newfield/Daughter				ckville,			
Baltimore,	es 1		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from Sta	cemetery crematory or other place)			Date 20	20c. Location - City or Town, State		
Ĕ	Pag ment ant: I ury o		4 □ Donation 5 □ Other (Specify)	Loudon Pa				Baltimore,		
alt	pparti		21. Sign store Funeral Service Licensee	// S1	Name and Address	s of Facility oute Fune	ral and C	Cremation	Center	
_	80 E 8 9		Coneny S. 2011					1e, MD 20	852 Approximate	
н			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	ised the death. Do not ent in tine.	ter the mode of dyin	g, such as cardiac	or respiratory arres	l,	Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition							
	/Medical Examiner		resulting in death) Due to (or	as a consequence of):						
Н	344	100	Sequentially list conditions, b. Due to (or cause. Enter Underlying	as a consequence of):						
	ted	ulu	cause. Enter Underlying Cause (Disease or injury							
Tay leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):										
8760,	siciar b buri	dical	d.							
189	ficate g phys	edic					-			
XO	eath certific attending p	/W	IF FEMALE: 23c. If yes, outco		Tectonic pregnancy			23d. Date of del		
Cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): All Causes (Disease or injury that initiated events resulting in the underlying cause given in Part I. Acute Reval Failure Acute Myocardial Trifartion Also Mic.							Month		Day Year	
P.0	that the de led by the a detached	ted by Physician/Me	9 ☐ Unknown 9 ☐ Unknow	m						
	res tha igned be de		Part tl. Other significant conditions contributing to dear	th but not resulting in the u	inderlying cause giv	en in Part I.		cco use contribute to		
ord	w require been si should t		Acute Renal Failure			-	1 ☐ Yes	2 X No 3□Pr	obably 4 Unknown	
Records,	e faw r has be je 2 sh	Completed	Acute Myocardial Info	oration			24a. Was an autopsy	prior to	topsy findings available completion of cause of	
<u></u>		Son	Anemia)			performe 1 ☐ Yes 2	ed? death? No 1 ☐ Yes	2 No	
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?		104		ath (Check only one))		
of V	Physician: this certific al director,	2	1 ☐ Yes 2 No Hospital: 1 X top	patient 2 ER/Outpatie		4 🔲 Nursing 🗅		ce 6 Other (Spe	cify)	
	Jing P	iuo	Natural Surending	Injury 28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe how	v injury occurred		
sio	Attending in death. •ctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be 28e Place 0	f taiun, - At home farm et		192 5 140	28f Location (Stre	eet and Number or Ri	ural Route Number.	
27. Manner of Death Solicide City or Town. 286. Date of Injury 286. Injury										
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and								due to the cause(s) and manner as stated.		
	24 hc 24 hc Fun stely	edical	29a. Certiffler (Check only one) 29b. Certiffler 29a. Certiffler (Check only one) 29b. Certiffler 29a. Certiffler (Check only one) 29c. Certiffler 29b. Certiffler 29c. Certiffl							
Second S							number 29d. I		Date signed (Month, Day, Year)	
	VV°	To less the second			D006	D0060117 Fel			b 20, 2004	
		30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)							-	
			Eric J. Park 9901 Medic		ive Rock	cville W	D 20850	>		
2		ate		gistrar's Signature	1					
	Regist	rar	FED Z 4 ZHI4	ENER /7	100.0	- /				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 07536 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Coleman 7:32a M Michele Louise February 26, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 14115 Weeping Willow Drive, Apt.#12 Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) Birthplece (Stete or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 280 F Virginia 219 64 9601 Director July 20, 1959 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23s or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral, or items 23s or 28e-f show Examiner must be notified at 1 Yes 2 No Director Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 14115 Weeping Willow Drive, Apt.#12 Funerai Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 21 No If Yes, Give Year or Dates: tx Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Wedical 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) Cotlege (1-4or 5+) 4 Civil Engineer Consulting Firm 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Townley Michael Coleman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9960-A Bauhinia Tree Way, Boynton Beach, FL 33436 Mary F. Coleman/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 27, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2004 Metropolitan Crematory 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funerat Service Licensee 1/11 Melbery 500 University Blvd. W., Silver Spring, Maryland 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition **Physician** Glioblastoma Multiforme 10 months resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physicien Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part It, Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2√ No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? certificate 2 No 1□ Yes ⊋□ No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home SCResidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the within 24 hours after deatl To the Funerel Director: 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and titte of certifier with Ingomo D 23308 February 26, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date fited (Month, Dey, Year)

FEB 27 2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

Victor M. Priego, M.D., 6420 Rockledge Drive, #4100, Bethesda, Maryland

State of Maryland / Department of Health and Mental Hygien 2004 07537 1- State AMEND#10a, 10c, 19aperFH2/27/04, EMMC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2-23-04 Kenneth S. Corey 1:25 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 128-07-8341 84 5-9-19 NY Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f ehow event, the Medical Examiner must be nutified at 1 ☐ Yes 2 ☐ No Director D.C. Washington, D. C 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or itams 23a Rock Creek Church Rd. at Upshur N.W. 20217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "ns any injury or other treumatic event, Ita Madig once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Food Administration Hospitals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Corey Mae Oaks 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda I. Corey - wife 2127 Worthington Greens Dr. Sun City Center, FL 33573 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 3-29-04 Arlington, VA 21. Signature of Funeral Service Licen 22. Name and Address of Facility Hines-Rinaldi F. H. Mari 11800 New Hampshire, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal failure 4 months /Medical Due to (or as a consequence of): Examiner Multiple myeloma 18 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, Coronary artery disease 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an <u>Sick sinus syndrome</u> page 2 autopsy performed? 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 🔯 Natural 5 Pending To the Hosping.

within 24 hours after death.

To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D09470 Feb. 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, M. D. 10400 Connecticut Ave. Kensington, MD 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 27 Registrar 2004

Senneth

	1	State Registrar			Cer	tificate	of D	eath			Reg. N	lo.		38
Dhaminin		1. Decedent's Name (First, Middle, La							1	Date of Do Month	eath D	ay Yee	3. Time of	
Physicia /Medica	al _	BRYAN O.	CORT							EB.	24,		3:15	Ам
Examine	er '	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Too		ocation of 0				lc. County of D MONTGO		
		Casey House 5. Social Security Number 6.5	7 Ag	e (In vrs. la	ast birthday)	If Under 1 Y		f Under 24		Date of B			Birthplace (State or Country)	Foreign
Funeral Director			M 2□F	78	Yrs.	Months D	Days	Hours	Min.	Date of Bi (Month, D	ay, Yea 19,	1925	Guyana	
>	-	Usuel Residence of Decedent 10a. State 10b. County		10c City	, Town or Loc	cation					-		10d. Inside Cit	v Limits
i, or items 23a or 28a-f ahow xaminst must be mutilled at		MD Montgo	mery	loc. Only		nantow	٧n						M∏Yes	
r 28a-	Director	10e. Street and Number				10f. Zip Co	ode				10g. C	Citizen of What	Country?	
23a o	aD	18513 Split	Rock Lan	ie .			208					U.S.F	A	
ems et m	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		3. V	Vas Deceden Yes, specify	nt of Hisp Cuban,	anic Origin Mexican, P	? (Specification Rice)	y Yes or N an, etc.)	0-	Black, W	merican Indian, /hite, etc.	
45. 32.0	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 €2€ If Yes, Give Year or Dates:	No	1	□Yes XŒ	No .	Specify:				Specity: E	Black	
"natural",	eted	15. Decedent's E (Specify only highest gr			16a. Deced (Give	lent's Usual C kind of work of OO NOT use i	Occupation done dur	on ring most of	f working		16b.	Kind of Busine	ss/Industry	
Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany injury or other traumatic avant, the Madical once.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		curit		Guard			R	ockefe	eller Co	٠.
vant,	Bec	17. Father's Name (First, Middle, Last					11					en Sumame)		
arked atic a	2	Johnson Cor	t									dney		
I B III		19a. Informant's Name/Relationship (Marcus M. Con			1	,						or Town, State	e, <i>Zip Cod</i> e) , MD 208	374
Health em 27 ther t	1	20a. Method of Disposition	(3011)	20b. PI	ace of Dispo	-	0.50	TOCK	Date		20c.	Location - City	or Town, State	
Department of Health Important: If item 27 any injury or other tr. once.	1	1 Burial 2 □ Cremation 3 5 1 □ Donation 5 □ Other (Speci		1	1				/4/0	4	C	orenty Guyan	yne Berl	bic
ortan injur		21. Signature 1 uneral Service Line	2 /-/-	Auc		Name and A	Address	of Facility				UNERA	L HOME,	
Depa Impo any ir		Derige,	Sugu	-del-	2	46 N.	Was	sh. S	St.,	Roc	kvi	lle, I	MD 2085	0
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each li	d the death	Do not ente	er the mode o	of dying,	such as ca	rdiac or re	espiratory	arrest,		Approximate Interval Bety	veen
ysician		Immediate Cause (Final disease or condition	Pros	state	Can	cer							Onset and D Year:	
ledical iminer		resulting in death)	Due to (or as	a consequ	ience of):									
	<u>-</u>	Sequentially list conditions, Tary, leaving to immediate cause. Enter Underlying	b. Due to for as	a consequ	ience of):									
dansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
physician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	ience of):									
hysici the bu	dicai		_ d		-	·								
ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ncy							23d. Date of	delivery	
ed by the attending properties of the detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 4 Pregnant at	2 Fetal	death 3	Ectopic pregi Other (speci						Month		'ear
r death. octor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Phy	9 ☐ Unknown Part II. Other significant conditions	contributing to death b	out not resu	ulting in the ur	nderlying caus	ise given	in Part I.		23a. Did	tobacco	o use contribut	e to the cause of d	eath?
been signe should be o	d by					,				1] Yes	2 ∑X No 3 □	Probably 4 DU	Inknown
shoul	Completed									24a. Wa		24b. Were	autopsy findings	available
2 5	dwo								_	aut	opsy formed?	prior death	to completion of ca	ause of
is certificate ha	0	25. Was case referred to medical					2	26. Place of	Death (0					
this cer al direct	To B	examiner? 1 ☐ Yes XXNo	Hospital: 1 Inpatie	ent 2	ER/Outpatien		Other:	4 🗌 Nursi	ing Home	5 □ Res	sidence		Specify/Hosp	ice
	on:	27. Manner of Death ¶∏Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ary Year)	28b. Time of Injury		. Injury a Work?			d. Describe	how in	jury occurred	5	
tor: A the fu	cati	2 Accident investigation	00 - 01(1-	ium, Ash-	ma farm at	M ant factors of		s 2∏No		Location	(Stran-	and Number of	r Rural Route Num.	ber
Direc Direc in by	Certification:	4 Homicide determined	28e. Place of In building, et	tc. (Specify	me, rarm, str	eet, ractory, c	OITICE		201	City or To	own, Sta	ate)	riardi riodia Malli	JO',
10 = D			hysician: To the best miner: On the basis of)
Funeral Funeral tely filled	Ic		and manner of	ated		vestigation, in	Trity Opii	non, death	occurred	at the time	,	and place, and	000 10 11/0 000000	
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exa	and manner st	ated.			License r		00001160	at the time			onth, Day, Year)	

State Registrar Joseph Kaplan,
31. Date filed (Month, Day, Year)
FEB 27 2004

M.D. 6001 Muncaster Mill Rd., Rockville, MD 20855

32. Registrar's Signature

Society

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State of Maryland / Department of Health and Mental Hygiene 2 0 0

COUR	INEY S.	C	For	State of Ma	ryland	/ Depa	artment	of H	ealth a	and M	lental Hy	giene	2004	07	539
	*		State Registrar Unpend Item Decedent's Name (First, Middle, I	723a,2/,28a-1,	Per ME,	(8 29 ;	y 16/04	eg i i	Jean		2. Date of De	Reg. No.		3. Time o	
	Physici /Medic			Courtney	S.	Cram	ner				Month FFB	Day 24	7 Year 2004	2020	РМ
	Examin		4a. Facility Name (If not institution, g SUBURBAN HOSPIT	ive street and number) AL				Town, or HESI	Location o	of Death			County of Death		
3318	Funeral Director		572-04-5941	Sex 1 ☐ M 2 🗓 F	(In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Di July 1	rth ay, Ye <i>ar)</i> 7, 19	9. Birth Co. Cali	place (State on intry) fornia	or Foreign
117	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation							10d. Inside C	ity Limits
	a-f sh	ctor	Maryland Montgo	mery	Ro	ckvil	1e							1 🗌 Yes	2 <u>N</u> 0
	or 28	Director	10e. Street and Number				10f. Zip						zen of What Cou	·	
	eath v	Funeral	6010 California	Circle, Ap			Was Deced	208.		igin? (Sp	ecify Yes or No		ed Stat		
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or Items 23a or 28a-1 show other traumatic event, the Medical Examinal mant be nullified at	by	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?			fYes, spec 1□Yes 2		Specify:		ecify Yes or No Rican, etc.)	i	Black, White Specify: Wh	, etc.	
2-0	72 ho	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Deced	ient's Usua kind of wor DO NOT us	l Occupa	ation Juring mos	it of work	ing	16b. Ki	ind of Business/l	ndustry	
121	within 808. than	ldmc	Elementary/Secondary (0-12)	College (1-4or 5-	+)		00 NOT us er / S					Se	1f Empl	oved	
d 2	illed Hygir other	0	17. Father's Name (First, Middle, La		-						e (First, Middle				
/lan	uld be Menta urked	To B	Douglas S. Crame	r, Jr.					Jo	yce	Haber				
Man	2 sho and I Is mu		19a. Informant's Name/Relationship										r Town, State, Zi		2
e,	1 and Health		Douglas S. Crame 20a. Method of Disposition	r, Jr. /Fati	20b. Plac	e of Dispo	sition (Nam	e of	T		Date		necticut)
TO E	Pages ent of Tr: # it		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1	-	natory or ot Cremato	,		Febru 27, 2			nesda, M		d
Baltimore, Maryland 21215-0036	permit. Pages 1 Department of H Important: If iten any injury or oth		21. Signature of Funeral Sovice Lice	ensee /	101305	Ro	Name and Dert A	Address Pum	s of Facility	ty Fune:	ral Home,	/Rockv	ville, Inc , Maryland	2.	
7	₹ }		23a. Part 1 Enter the disease, or co	mplications that caused by one cause on each lin	the death.	Do not ont	or the made	of chain	a such as	cardino	or coonicators o	ero et		Approxima	10
	Pnysician	8 0	shock or heart failure. List on Immediate Cause (Final disease or condition	Gastrointe	estanal	. Hemor	rhage (Compl	icatir	ng Acı	ite Alcoh	iol In	toxicatio	Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequer	nce of):									
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequer	nce of):		-							
	be executed sician and burial-transit	Examine	triat mitiated events	C.											
30,	ate be executed hysician and the burial-transit	i Ex	resulting in death) Last	Due to (or as a	consequer	nce of);									
8760,	ate the	dicai		d											
Division of Vital Records, P.O. Box 6	The law requires that the death certificate has been signed by the attending ploage 2 should be detached for use as I	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3	Ectopic pre					2	23d. Date of deliv	,	Year
م.	ires that the de signed by the a l be detached f	by Ph	Part II. Other significant conditions	contributing to death bu	ıt not resulti	ng in the u	nderlying ca	iuse give	en in Part I		23e. Did	tobacco u	ise contribute to	the cause of c	feath?
rds	w require: been sig should be					·					10	Yes 2	□No 3 □ Pro	bably 4 🛭	Unknown
I Reco	en: The law re tificate has be- ior, page 2 sho	Completed											24b. Were aut prior to co death?	opsy findings ompletion of o	available ause of
Vita	ici eci	Be	25. Was case referred to medical examiner?	Hospital:				Oth			h (Check only				0.000
of	Phys this ral dii	. To	1 XYes 2 No 27. Manner of Death	1 L Inpatier		VOutpatien 3b. Time of	t 3 DO	A Othe Bc. Injury Work	40140	ursing Ho	me 5 Resi		6 □Other (Speci v occurred	fy)	_
ion	nding f ath. r: After e funer	atior	1 □Natural 5 □ Pending 2 □ Accident investigat	28a. Date of Injur TOUME th, Day		Injury unkn o	M		<br Yes 2 .	No	unknown	,	,		
ivis	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ertification:	3 Suicide 6 A Could no determine	DB 290 Place of lain				office					d Number or Rui		
۵	pital o	O	29a. Certifier 1 ☐ Certifying	Physician: To the best of					a data an			E VII	With the terminal	- 11	
	To the Hos within 24 ho To the Fun completely	edicai	(Check only one)	aminer: On the basis of and manner sta	examination	and/or in	vestigation,	in my op	oinion, dea	ath occur	and due to the red at the time,	date and	and manner as: I place, and due	stated. to the cause(s	s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c.		number				e signed (Month	-	
			▶ QuetL					0.0	C.M.E			FE	EB. 25,	2004	
			1	EUBIO, HD	11	.1 Per	n Str			timo	ore, Mai	rylan	d 21201		
34	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 7	2004 32. Registra	ır's Signatur	° &	Sp	ack	2						

B.K. 5	Please Type of Print in Black indelible ink. Ensure	e All Copies Are Legible.	
3ETTY	CRAWFORD State of Maryland / Department of Health and	d Mental Hygiene 2004	0751.0
	1 - State Registrar AMEND ITEM #10e PER FH G829 3/17/04 Contificate of Death	Reg. No.	07040
	1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
DI	nusician	Month Day Year	10 • 21 D ·

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural; or Itema 23a or 28a-1 show any Injury or other treumatic event, tra Medical Erantment be routilised at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Registrar AME	ND ITEM	#10e PER FI	1 G829	3/1//04	TOFF (mean	eon	Jealli			Reg. No	o		
	1. Decedent's Name	e (First, Middl Betty		ford							2. Date of Do Month FEB	11,	200		3. Time of Death 10:21P M
	4a. Fecility Name (h BOWIE H		n, give street and nu CENTER	ımber)				Town, or WIE	Location	of Death			RINC		ORGES
	5. Social Security N 374 36 21		6. Sex 1 □ M 2 □ F	7. Age (In yrs. last bir 64	thday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Feb • 23	rth a <i>y, Year</i> 3,193	39	9. Birth	place (State or Foreign ntry) Wash.,D.C
	Usual Residence of	Decedent													
	10a. State	10b. County	nce George		Oc. City, Tow West			ri 11 <i>e</i>	.				10d. Inside City Limits 1,□ Yes 2 □ No		
ŀ	10e. Street and Nur		4923 LASALLI			119 0	10f. Zip					10g. Ci	itizen of W	/hat Cou	ntry?
			itario Way						2078	2			TT	SA	
-		Jake OI			er in II C	12 14	las Dass	dans of U			noifu Vae or N	<u></u>			can Indian,
	11. Marital Status		12. Was Dec Armed F	orces?	ei iii ().3.	IS. W	Yes, spec	city Cuba	in, Mexica	n, Puerto	ecify Yes or N Rican, etc.)			k, White	
	1∑ Never Mam 3 ☐ Widowed	_	If Yes, G	2 X No live Dates:		1	Yes	2X No	Specify.				Specify.	В1ас	:k
		city only highe	nt's Education ast grade completed			(Give k	ent's Usua and of wo ONOT us	rk done	durina mos	t of work	ing		Kind of Bu		•
-	Elementary/Seco 12yea		College 2yea	(1-40r 5+) Ars			ırse		,			Hea	alth	Care	<u> </u>
	17. Father's Name	(First, Middle,	, Last)								First, Middle		n Sumam	e)	
		Jeffers	son Crawfo	ord						Lula	McMoor	e			
	19a. Informant's Na Lisa Gal						Bowie				o Code)				
		Cremation	3 Removal from	n State		ry, crem	atory or c	other plac			Date / 2004		ocation ·		own, State
	* 4 □ Donation 21. Signature of Fy	// -	71		Gate	_						_		Spri	-11g
	23a. Perm. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	art failure. Lis (Final on	or complications that at only one caus to	each line	ne death. Do	not ente	3015	121	h St	reet	neral N.F. pr respiratory	Wash		C. 2	20017 Approximate Interval Between Onset and Death
completed by a mysterial medical Evaluation	Sequentially list cor dany, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	njury s	1		consequence										
,	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	2 months? □ No		birth 2 gnant at ti	pregnancy Fetal death me of death	3 🗆 1	Ectopic p Other (sp	regnancy pecify)					23d. Date Mor		rery Day Year
	Part II Other signi	ficant condit	tions contributing to	death but	not resulting	in the un	derlying	cause giv	en in Part	l.			use contr		the cause of death? bably 4 []Unknown
our piece	<u>Chole</u>	eyste	chang i	rece	rt						24a. Wa auto pen Y2 Yes	opsy formed?	P	Vere autorior to colleath?	opsy findings available ompletion of cause of 2 No
	25. Was case refe	rred to medic	al						26. Plac	e of Deat	h (Check only	one)	/	1	
	examiner? 1 X es 2 2			Inpatient		utpatient Time of		OA Oth	4 🗆 N	ursing Ho	me 5 Res	_			(ty) AT SCEN
	2 Accident	5 Pend inves	ling (Mo	onth, Day	Year)	Injury	м	Wol	k? Yes 2□]No	200. 0030:100	, now my	ary occurr		
	3 Suicide 4 Homicide	6 Could deter	mined 286. Plat	ce of Injur Iding, etc.	y - At home, f. (Specify)	arm, stre	et, factor	y, office			28f. Location City or To			er or Rui	al Route Number,
27. Manner of Death Statural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office 29e. Certifier 1 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 29e. Signature and title of certifier 29e. License number 29e.							nd place, ath occur	and due to the red at the time	e cause(: e, date ar	s) and ma nd place, a	nner as and due	stated. to the cause(s)			
	29b. Signature and	title of certifi	ier Da	^			29c. License number 29d. Date signed (Month, Day, Year) C.C.M.E FEB. 12. 2004								
	30 Name and add	tress of person	in who completed ça	use of dea	ath (Item 23a)	133, 12, 2001									
	J-LA	201	s lever	8	\mathcal{O}_{111}	Peni	n St	reet	, Bal	timo	re, Mai	ryla	nd 21	201	
	31. Date filed (Mo	nth Day Yea	(r) 32.	Registrar	's Signature							- 42			

State

				State of Maryland			lealth and N	lental Hygie	ne	
		1	State	State of Marylane		tificate of l			No. 2 A A 1.	07511
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death	2009	3. Time of Death
	Physicia	ın	Carolyn Mishel	le Cozzen-Mor	ton			Month February	Day Year 11 2004	4:15 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
	LAdiiiii	æ1	Southern Marylan				Clinton		Prince (
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	24	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	ear) Co	hplace (State or Foreign buntry)
	Director	-	578-80-3986	4	5 Yrs.			Nov. 29,	1958 Wa	ash., DC
	and	⊢	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Mary	Į į	Maryland Prince G	eorge's		Clinton				1 X Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	
	h with		5331 West Boniwo	od Turn			20735		Prince G	
	deat	Funeral		12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 💢 No	Specify:		Specity:	Black
Ö	filed within 72 hours after death with the Maryland Aggiene. other than "natural", or Items 23a or 28a-f ahow other than "natural", or Items 23a or 28a-f ahow ant, the Madical Examiner must be notified at	q pe	15. Decedent's Edu	Year or Dates:	16a, Dece	dent's Usual Occup	pation		b. Kind of Business	/Industry
5	in 72	olete	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of work	king		
212	d with	Completed	Elementary/Secondary (0-12)	3		Paralega	1 Specia			rnment
פ	al Hyg other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, Ma		
<u>Ja</u>	Wents Ments wrked	70	Purcell Cozzer					Viola M.		= 0 ()
Maryland 21215-0036	and le ma		19a. Informant's Name/Relationship (Ty					ral Route Number, C urn, Clint		20735
2 o	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f ahow Important: If item 27 is marked other than "natural; or Items 23a or 28a-f ahow any injury or other traumatic avant, the Modical Exp. ulner must be notified at any injury or other traumatic avant, the Modical Exp. ulner must be notified at any injury or other traumatic avant, the Modical Exp. ulner must be notified at	1 13	Donte Holley - S	20b. Pl	ace of Disp	osition (Name of		A Committee of the Comm	c. Location - City or	
Baltimore,	in it of h		1 Burial 2 ☐ Cremation 3 ☐ R	compared from State	emetery, cre	matory or other pla	Park 2/1		Landov	
≣	it. Partmer intent injury	1	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerat Service License		mony 2	2. Name and Addre	ess of Facility S	tewart Fu		
Ba	permi Departiment Impo		Delas T S	tewart III	-			, N.E. Was		20019
4	8		23a. Part 1 Enter the disease, or compl shock or heart failure. List only or	cations that caused the death	. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between
is.	Physician		Immediate Cause (Final disease or condition	Sepsis	>					UNKNOW
-34	/Medical		resulting in death)	Due to (or as a consequ						
	Examiner		Sequentially list conditions,	J						
Jin .	p tis	Examiner	Sequentially list conditions, If any, Isaamy to in mediate cause. Enter Underlying Cause (Disease or injury)	Due to for as a consequ	Jence of):					
	be executed ician and burial-transit	хаг	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
760,	te be executed ysician and ie burial-transit	calE		4						
687	leath certificate b attending physi I for use as the t									
Вох	death certifical e attending phy od for use as th	M	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		□Ectopic pregnanc	:v		23d. Date of de Month	olivery Day Year
	0 0 0	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of di 9☐Unknown		Other (specify) _			MOHIII	Day Todi
P.O.	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/Medi	9 ☐ Unknown Part It, Other significant conditions co		. Wine in the	underhing gauge gr	von in Part I	23e Did toha	cco use contribute	to the cause of death?
	res th	þ	splenctony	Tributing to death but not res	usung in the	urideriying cadse gi	VOIT III P GILL.			Probably 4 Mnknown
orc	w require been sig should t	eted	- Spareer, sug					24a. Was an	24h Were s	untoney findings available
3ec	The law cate has t page 2 s	Completed						autopsy	prior to death?	completion of cause of
a		e Co	25. Was case referred to medical				26 Place of De	1 Yes 25 ath (Check on one		\$ 200110
of Vital Records,	Physician: this certific ral director.	0	avaminar?	Hospital: 1 Inpatient 2	ER/Outpatie	ent 3 DOA		lome 5 ☐ Residen		ecify)
1 0	g Phye er this eral dir	-	27. Manner of Death	28a. Date of tnjury (Month, Day Yeer)	28b. Time Injury	of 28c. Inju		28d. Describe how		
ion	ath. or: Aft	atio	1 Acturat 5 Pending investigation			M 1]Yes 2 □ No			
Division	il or Attending Patter death. Director: After the bin by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At he building, etc. (Specif		treet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
Ω	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funes	Cel	Con Contine All Constitute Div	vsician: To the best of my kno	wledge do	ith accurred at the l	lime date and place	a, and due to the car	ISB(s) and manner	as stated.
	Hospita 24 hours Funeral stely filled	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	iner: On the basis of examina and manner stated.	tion and/or	investigation, in my	opinion, death occi	urred at the time, dat	e and place, and du	ue to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier			29c. Licen	ise number	29	d. Date signed (Mor	
)	F * F 2	}	Rainta Fara	With M.D.		Î.)43446		2/11/0	4
2	(2)		30. Name and address of person who o	ompleted cause of death (Iter	n 23a) (Type	e, Print)				Δ .
	(d)		30. Name and address of person who of RSINTAN FARAL			Geo.gua A	12 1011 3-	41 911vn.	pring M	D 20902
	St	ate	31. Date filed (Month, Day, Year)	22. Registrar's Signa	ature	180				

MORTON CHROLYN

		1 - For State Registrar 1. Decedent's Name (First, Middle, La		il ylarid /		rtificate of L		2. Date of Do	Reg. No.	200L	3. Time of Death
Physicia /Medic Examin	al	MARY T 4a. Facility Name (If not institution, given the ster River to Security Number 16.5)	Manor	COU	RSE'	4b. City, Town, or Cheste	rtowr	MARCH Death	6 20 4c. C	ounty of Deal	thplace (State or Foreign
Director		222-20-0181 Usual Residence of Decedent 10a. State 10b. County	□M 2020 F	91 10c. City, To	Yrs.	Months Days	Hours	Hrs. 8. Date of Bi Min. (Month, D Aug 1	9 191	2 Mai	10d. Inside City Limits
th the Mary or 28a-f she e notified	irector	MD Kent 10e. Street and Number		Ga1	ena	10f. Zip Code			10g. Citize	en of What Co	1 X Yes 2 □ No
2 should be liled within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel; or Items 23s or 28s-f show sumatic event, the Medical Examinational be notified.	by Funeral Director	108 West Cross 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1		1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origir n, Mexican, I	1? (Specify Yes or N Puerto Rican, etc.)	0- 14	S • A • Race - Ame Black, Whit	
d within 72 hou giene. In then "neture the Medical E	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 1 2	ducation ade completed) College (1-4or 5		(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired okkeeper	during most o	f working	16b. Kind	of Business	/Industry
0 = 0 >	To Be C	17. Father's Name (First, Middle, Last John Raymond	Thornley				Ida	Name (First, Middle B. McInt	tyre		
permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		19a. Informant's Name/Relationship (Donald Othoso 20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ 1 □ Donation 5 □ Other (Speci	n (nephe	20b. Place	108 e of Dispo	•	oss S	or Rural Route Numb St. Galer Date 3/7/04	na, M		.635 Town, State
permit. Departr Imports any inju		21. Signature of fune al Serv		10051		alena f 18 West	unera Cros	1 Home o	of St alena	ephen	L. Schae 21635
Cate be executed by Science be executed by Medical Examiner transit stee partial transit steep by Science be executed by Science by Science be executed by Science be executed by Science b	cal Examiner	23a. Pant1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ACL 72 Due to (or as a	e. a consequent	1316- ce of): ce of):	mme		MUR DI		-	Approximate Interval Between Onset and Death
ath certifica attending ph tor use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal de	ath 3[□Ectopic pregnancy □ Other (specify)			23	d. Date of dei	livery Day Year
quires that the de n signed by the a uld be detached		Part II. Other significant conditions	contributing to death bu	ut not resultin	ig in the u	nderlying cause give	en in Part I.			_	the cause of death?
	Completed								s an opsy ormed?	death?	utopsy findings available completion of cause of 2 No
Attending Physicien: Th r death. sctor: Atter this certilicate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 10 27. Manner of Death 1 Chatural 5 Pending investigation	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day		/Outpatie b. Time o	f 28c. Injury Work	er: 4 D Nors	f Death (Check only ing Home 5 ☐ Res 28d. Describe	idence 6		cify)
	Certification:	3 Suicide 6 Could not to determined	building, etc	(Specify)		reet, factory, office		City or To	own, State)		ural Route Number,
To the Hospitel or within 24 hours afte To the Funerel Dir completely tilled in	Medical		nysician: To the best of miner: On the basis of and manner sta	examination			oinion, death		, date and p		to the cause(s)
1		30. Name and address of person who	completed cause of de			Print)	3724	·		7-04	
Sta Registr		John C. Sey 31. Date filed (Month, Day, Year) MAR 11 2	mour M.D 32. Registra	. 12 ar's Signature		peer Rd.		stertown	, MD.	2162	20

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month February **Physician** 2130 M CRAIG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Prince George Clinton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** 59 1 ☐ M 2 🖼 F October 30,1944 Washington DC Director 577-62-4401 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or than "natural", or Items 23a or 28a-f show the Middest Examiner rount be notified at 1 Yes 2 No Director Maryland Prince George Capitol Heights 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20743 United States 1116 Kayak Avenue death Funerai 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. I □Yes 2X No I Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Ite iry or other traumatic event, the Middeal Examine. 1XX Never Married 2 ☐ Married 1 ☐ Yes 200No Specify: Specify: Black Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Sibley Hospital Elementary/Secondary (0-12) College (1-4or 5+) Twe1th Supervisor - Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia Campbell Howard Craig ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3314 Curtis Drive #203, Hillcrest Heights MD 20748 Marie Dorsey 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February permit. Pages 1 Department of H Important: If Ite sny injury or ot once. 1

Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park 13,2004 Landover, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen Robert G. Mason Funeral Home 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 12 Hours **Physician** Urosepsis resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth Month Year in the past 12 months? for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo P.0. detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Tes 25 No 3 Probably 4 Unknown Terminal Cerivcal Cancer Completed peen Terminal Pancreatic Cancer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 3 ☐ No autopsy performed? **¾**□ No 1 Yes 2 🕅 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XXER/Outpatient 1 ☐ Yes 2 🛱 No Certification: To 3□ DOA no Hospre... in 24 hours after death. the Funerel Director: After this ∈ this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0060552 February 9, 2004 Win 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19703 Executive Park Circle, Germantown, Maryland 20894 Steven Paul Fong, M.D. 31. Date filed (Month, Day, Year) FEB 1 8 2004 B2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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	Examin				give street and num	nber)				Location of Dea	ith		4c. County			
				enwick La						Spring			Montgomery			
	Funeral Director		5. Social Security Unknows	n	3. Sex 1 ☐ M 2 ☐ XF	7. Age (In	yrs. last birthday 2 Yrs.	Months	Days	If Under 24 Hr Hours Mir	s. 8. Date of (Montile 05	08 41	ar)	9. Birthi Coul New	place (State or Foreign http:) York	
pue	> _		Usual Residence 10a, State	of Decedent 10b, County		10	c. City, Town or L	ocation						1	I Od. Inside City Limits	
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aryidilla 61615-0050 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinat must be nothing at once.	by Funeral Director		rried 2 Marrie	If Yes, Giv	rces? 2] No e	in U.S. 13.	Was Dec If Yes, sp 1 ☐ Yes		ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes on the Rican, etc.	or No- c.)	Blac	e - Ameniek, White, "Bla		
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O. DOX 60/	been signed by the attending phys should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was deceded in the past 1 1 Yes 2 9 Unknow	12 months? 2 ☑•No	23c. If yes, out 1 ☐ Live b 4 ☐ Pregn 9 ☐ Unkno	irth 2 🗀 ant at time	Fetal death 3	□Ectopic □ Other (s				_	23d. Dat Mo	e of delive	ery Day Year	
ecords, P.O.	n signed b Ild be deta	ρ	Part II. Other sign	nificant condition	s contributing to de	ath but no	ot resulting in the	underlying	cause give	en in Part I.		Did tobacc		ribute to tl 3 ☐ Prob	ne cause of death?	
r e	2 3	Completed										Was an autopsy performed es 2	, ,	Vere auto rior to co leath?	psy findings available mpletion of cause of	
	tifica tor, p	0	25. Was case ref	erred to medical						26. Place of De						
<u>§</u> . <	is cer direc	O.B	examiner? 1 ☐ Yes 2	No	Hospital: 1 □1	npatient	2 ER/Outpatie	ent 3 🗆 🗅	Othe		4	,	6 □Oth	er (Specif	y)	
On OI	th. : After thi : funeral	tion; T	27. Manner of De 1 Natural 2 Accident	5 Pending	28a. Date (Mont	·	28b. Time		28c. Injury Work		-	ribe how in				
UIVISION I or Attanding	within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could no	200. Flace	of Injury -	At home, farm, s Specify)	treet, facto	ry, office			ion (Street or Town, St.		er or Rura	d Route Number,	
e Hospita	24 hours e Funaral etely filled	edical C	29a. Certifier (Check only one)		Physician: To the xaminer: On the ba		amination and/or i									
o the	within Fo the compl	Me	29b. Signature ar	nd title of confier				2	c. License			29d. l	Date signed	(Month,	Day, Year)	
	7		16	v.h.V	ms				27	1675		1=	el 19	1,20	64	
_	(0)			Idress of person w	ho completed caus	e of death	(Item 23a) (Type	, Print)	Dr.	, #41	00 R	6THE	570	MD		
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $200\,4$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Febru 6, 2004 Reginald Gordon Cain /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manuland 9. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 XM 2 ☐ F 578-76-1928 47 April 6, 1956 Wash., Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or Itams 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number With 21202 1165 Sargeant Street U.S.A. Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Nover Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify 3 Widowed 4 Divorced Black "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: if item 27 is marked other than any injury or other traumatic avant Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Technician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Johnnie Cain, Sr. Kathelean Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnnie Cain, Jr./Brother 1416 22nd St., SE, Wash., D.C. 20020 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) Fort Lincoln Crematory 2-12-2004 Brentwood, Maryland 21. Signature I Funeral Service License e 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to or as a consequence of) **Examiner** Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last Due to (or as a consequence of) Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed tabo Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? ambsc autopsy performed 2 No 2 12 No 1 TYes Division of Vital : After this certifical funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Atten within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide in by 4 Thomicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Hetely 29c. License number 29d. Date signed (Month, Day, Year) To t 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lu m ba 31. Date filed (Month, Day, Year) 32. Registrar's Signature

FEB 1 7 2004

			1 - For State Registrar	State of Maryland / Dep	partment of Health and leartificate of Death	Mental Hygier	_ZBU4_B/56/
			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	Physicia /Medic		Robert	Carter		February	
	Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Deat	h 4	4c. County of Death
			Prince George's Ho		Cheverly If Under 1 Year If Under 24 Hrs		Prince George's
	Funeral		5. Social Security Number 6. Sex	M OFF	Months Days Hours Min.	(Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		578-22-2459 Usual Residence of Decedent	78 Yrs.		Nov. 19, 1	1925 Washington, D.C.
	yland		10a. State 10b. County	10c. City, Town or t			10d. Inside City Limits
	B-f st	tor	Maryland Prince Ge	orges Mitchel	lville		1 1 Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
	23a	la	11411 Lake Arbor W	ay #411	20721	Ur	nited States
	hours after death with the Maryland Lural', or Items 23e or 28e-f show al Examinet must be notified at	Funeral	Tr. Maritar Status	Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
8	hour	ed b	15. Decedent's Educ		edent's Usual Occupation	16h	Kind of Business/Industry
5	in 72 n "na	Completed	(Specify only highest grade	completed) (Giv	e kind of work done during most of wor DO NOT use retired)	rking	netary
212	y with	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	ef Mail Clerk		cernational Fund
ğ	e filec I Hyg othe vant,	Bec	17. Father's Name (First, Middle, Last)			me (First, Middle, Maide	
<u>la</u>	Alenta Alenta rrked itic a	ToE	Robert Henry Carte	r	Corlene	O. Campbel	L1
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28a-1 show appring yor other traumatic avant, the Medical Examiner must be notified at 90ce.		19a. Informant's Name/Relationship (Ty)		ling Address (Street and Number or Ru		
_	1 and 1 Health tem 27		Carolyn Delores Ca	the same			ellville, Md. 20721
altimore,	Jes 1 of H If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State 20b. Place of Disp cemetery, cri	position (Name of ematory or other place)	Date 20c.	Location - City or Town, State
Ē	Pages iment of lent: If it jury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	Marylan		18,2004 Lau	
Ball	Department Importent: Importent: Importent: Once.		21. Signature of Funeral Service Ligense	6.4	Alexander 5. Pop 5538 Mariboro Pi	e Funeral I	Homes
	707 e d		Nih a- gar				
Н			23a. Part1. Enter the disease, or complied shock, or heart failure. List only on	e cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	DISSECTION OF	ADRTIC ANEI	IRYSM	
я	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
		-	Sequentially list conditions, if any, leading to immediate	. Due to (or as a consequence of).			
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	.,.			
	al-tra	хаг	that initiated events cresulting in death) Last	Due to (or as a consequence of):			
8760	death certificate be executed e attending physician and id for use as the burial-transit	dical					
89	tificat ig phy as the				70		700
Box	eath certif attending for use as	Physiclan/Me	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
	ne death the atte hed for	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		Other (specify)		Month Day Year
O.	at the de by the a stached	hys	9 Unknown				
ຜົ	The law requires that the te has been signed by the bage 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
ord	w requir been si should	ted				1 🗆 Yes	2 No 3 Probably 4 Nnknown
Ö	elawi hasbe je 2 sh	ple				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>		Completed				performed? 1⊠Yes 2□N	
Division of Vital Record	Attending Physician: The death. sctor: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	ospital:		ath (Check only one)	
ot	Physical this call dir	To .	f Yes 2 No 27. Manner of Death	ospital: 1 Inpatient 2 ER/Outpatie		lome 5 Residence	
L C	ding I h. After funer	lon	1 Natural 5 Pending	(Month, Day Yeer) 280. Time	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	ury occurred
S	or Attendii after death. Director: A in by the fu	ertification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s		28f. Location (Street a	and Number or Rural Route Number,
<u>≥</u>		ertii	4 Homicide determined	building, etc. (Specify)	noon lactory, onloo	City or Town, Sta	ite)
_	Hospitel 4 hours Funerel tely filled	O	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, dea	ith occurred at the time, date and place	and due to the cause	(s) and manner as stated.
	D Ho	edical	(Check only 2 X Medical Examination)	ier: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date a	nd place, and due to the cause(s)
	To the Hospitel or within 24 hours after to the Funerel Dir completely filled in	Me	29b. Signature and title of certifier	` .	29c. License number	29d. D	Pate signed (Month, Day, Year)
•	() Une L		O.C.M.E.	Fol	oruary 13, 2004
	15)		30. Name and address of person who co			1 6	OLUCLY 10, 2004
	0			WB10, MD 11:	l Penn Street, Bal	timore, Ma	ryland 21201
	Sta		31. Date filed (Month, Day, Year) FEB 1 7 2004	. Registrar's Signature	all I	•	_
	Registr	ar	LED I 1 5004	Maria Ja. Mille			

			1 - For State Registrar	State of Maryl		artment rtificate			and M		Reg. No.	2001	
	Physici	an	1. Decedent's Name (First, Middle, Last) Wesley		Curr	in				2. Date of De Month Februar), 2004	3. Time of Death 9:00 A M
	/Medio Examin		4a. Facility Name (If not institution, give s		ourr	4b. City, To	own, or l	Location o		- CDI dai		County of Deeth	
				.02				lills				ince Ge	orges
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Bir	th 1934	9. Birth	place (State or Foreign ntry) ington, DC
			578-46-0998 Usual Residence of Decedent	05	,					11/12/	1737	Wasii	riigtoii, bo
	arylan ehow	_	10a. State 10b. County Maryland Prince Ge		City, Town or Lo Temple								10d. Inside City Limits 1 ☐ Yes 2 No
	the M	Director	10e. Street and Number	orge s		10f. Zip C					10a Citis	zen of What Cou	
	3a or	Ö	2309 Olson Street	#102			0 74 8	2			rog. Oilia	USA	
	ams 2	Funeral		2. Was Decedent Ever Armed Forces?	in U.S. 13.1				gin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - Ameri Black, White,	
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ⊠Xes 2 □ No If Yes, Give	1958-	1⊡Yes X		Specify:	,	,		Specify:	White
2-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itams 23a or 28a-f ehow dother than "natural", or Itams 24a or 28a-f ehow event, the Medical Exercities mast be notified at	ted k	15. Decedent's Educ	ation	16a. Dece	dent's Usual	Occupat	tion			16b. Kin	nd of Business/In	dustry
2121	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work DO NOT use	retired)		of working	ng		D	
N	filed w Hygier Sther th		10 17. Father's Name (First, Middle, Last)		Gra	aphic (r's Name	(First, Middle,	Maiden !	Printi	-ng
au		To Be	UNKNOWN					10. 1110010		NKNOWN	retail_corr (our anno,	
Maryland	permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If Item 27 ie marked (any injury or other traumatic ev once.	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street ar	nd Numbe			er, City or	Town, State, Zip	Code)
	and 2 eelth m 27 i		Stephen W. Sanford						-			tucky 40	
altimore,	Pages 1 nent of H int: If ites iry or oth		20a. Method of Disposition 1) □ Burial 2 □ Cremation 3 □ Re	onioval nomi stano	b. Place of Dispo cemetery, cren					ate		cation - City or To	
	permit. Page Department (Important: If any injury or once.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens	7 7	ld. Veter	ans Co	em. Address	of Facility)2/17 v	7/2004	Chel	tenham.	Maryland
ä	Per Pep Per Per Per Per Per Per Per Per Per Per		Ar F. Ja	lop 1	Ge	eorge 160 Ox	P. K on H	alas Iill	Fune Rd	eral Ho Oxon H	me, lill.	P.A. MD 2074	45
			23a Hart1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the de cause on each line.	death. Do not ent	er the mode	of dying,	, such as	cardiac or	respiratory ar	rrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	END ST	ACIE	REN	AL	DIS	EA	SE			Onset and Death
è.	/Medical Examiner		resulting in death)	Due to (or as a con		STRU	CT1	NE	0.0	HUOVAT	7 V N	- 2022	
	Selection of the select	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a con		STRU	CI	() ()	Puc	100001	עוי-	170475	
	nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ARTER	JAL	OCC	زبن	NOV	0	2 45	Crs	>	
760,	ate be executed nysicien and he burial-transit	cal Ex	resulting in death) Last	Due to (or as a con		RUTER2	7	Di	CPA	SE			
	P S		d.	0000000	1 0 1	801012		000	30 6	10 6			
Вох	The law requires that the death certifics tie has been signed by the attending pt bage 2 should be detached for use as to	Physician/Med	ZSD. Was decedent pregnant	Bc. If yes, outcome of pre		Ectopic pred	ananov				2:	3d. Date of delive	эry
о. ш	at the deal by the att	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time 9☐Unknown		Other (spec						Month	Day Year
ď.	res that th igned by be detacl		Part II. Other significant conditions cont	tributing to death but not	resulting in the ur	nderlying cau	use giver	n in Part I.		23e. Did to	obacco us	se contribute to the	ne cause of death?
rds	quires n sign ald be	d by								1 🗆 Y	∕es 2 🗆]No 3 prob	ably 4 Unknown
000	aw require as been sig 2 should b	Completed								24a. Was		24b. Were auto	psy findings available
ž	The law cate has page 2 a	Com								autop perfor	rmed?/	death?	mpletion of cause of 2□ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:						(Check only o			
ō	Phys or this oral dia	J: To	1 ☐ Yes 2 ☑ No 27. Manny of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of	-	c. Injury a	`4 ☐ Nur at		e 5 Aesid 8d. Describe h		Other (Specif	0
on	Attending I r death. ector: After by the funer	atlor	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury	М) ∋s 2 🗆 N	10				
Division of Vital Records,		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, streecify)	eet, factory, o	office		2	8f. Location (S City or Tow		Number or Rura	I Route Number,
	Hospitel o		29a. Certifier 1 Certifying Physi	ician: To the best of my	knowledge death) occurred at	the time	data and	d place ou	ad due to the			
	To the Hos within 24 h To the Fun completely	edicai	(Check only 2 Medical Examinone)	er: On the basis of exam and manner stated.	nination and/or inv	estigation, ir	n my opi	nion, deatl	h occurre	d at the time,	date and p	place, and due to	the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier			29c. I	License	number			29d. Date	signed (Month,	Day, Year)
l	1161		disamos	Cui		D	481	28			Febru	ıary 12,	2004
10			30. Name and address of person who con			,	0	77.		MD 00=	, -		
	Sta	te	Sisom Osia, M.D. 31. Date filed (Month, Par, Year)	6192 Uxon 32. Registrar's	nall Rd.	#500,	, Ux	on Hi	LLL,	MD 207	45		
	Registr		FEB 17 2004 DE	and to									

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 20 2004 5:30 РМ **ESSIE** CARROLL February /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5027 BLADENSBURG PRINCE GEORGE'S 57th AVENUE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, March 1 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🔀 F Director Ĩ911 MARYLAND 92 March 220-34-8950 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinar must be mailfied at MD PRINCE GEORGE'S BLADENSBURG 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5027 57th AVENUE 20710 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLACK ģ Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental 1 and 2 should be WILLIAM MACK PINKNEY BERTHA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DELORES P. CARROLL/DAUGHTER 5027 57th AVENUE BLADENSBURG, MARYLAND Baltimore, Hem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 2-25-2004 LANDOVER, MARYLAND 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee once. - Ma D 7474 Landover Road Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RENAL FAILURE **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** CHRONIC ISCHEMIA HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and physicien are the burial-t Due to (or as a consequence of): Box 68760. Physician/Medical as attending IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No Ö the detached 9 Unknown 9 Unknown signed by 1 d be detact ے The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 24 No page certificate 1 Yes Physician: rector, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 X Natural s after dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical pletely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0101029800 2/24/04 30. Name and address of virson who completed cause of death (Item 23a) (Type, Print) 4715 N. 15th Street Arlington, Virginia Hank Willner M.D. 31. Date filed (Month, Day, Year) FEB 2 4 2004 2. Registrar's Signature State Registrar

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		1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of rtificate o	Health and f Death		Reg. No.	2004	
Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) JAMES LEON 4a. Facility Name (If not institution, give s			4b. City, Town	n, or Location of De	2. Date of De Month FEB.	22 Day	Year 2004 County of Deat	3. Time of Death 10:450 M
Funeral Director		211 00 3131		Vec	CLIN If Under 1 Ye Months Day	ar If Under 24 H	8. Date of Bin (Month, Da MAR 8	th v. Year)		GEORGE ** S splace (State or Foreign untry) OC
death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	Usual Residence of Decedent 10a. State		y, Town or Lo	LE HIL			10g Citi	zen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
IIIQ X IX I 3-0030 be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Items 23a or 28a-f show avent, I'm Medical Examinat must be notified at	by Funeral Di	2712 BELLBROOK 11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2↓ No If Yes, Give		207	48 of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		USA 14. Race - Ameri Black, White	rican Indian, o, etc.
A I X I D-UUSO d within 72 hours after giene. r than "natural", or Ite tra Medical Examina	Completed b	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 10	Year or Dates: cation completed) College (1-4or 5+)	(Give life.	dent's Usual Occ kind of work do DO NOT use ret STODIA	ne during most of v ired)	working		nd of Business/I	COMPLEX
Taryiand Z 2 should be filed and Mental Hygi is marked other aumatic event, I	To Be C	17. Father's Name (First, Middle, Last) LESTER CHEW				1	lame (First, Middle,			
2 5 E C E	7 1	19a. Informant's Name/Relationship (Ty) MATILDA CHEW	SISTER)	2712	BELLB	ROOK ST	. TEMPL	E HI	LLS, N	1D 20748
Dallinoie, permit. Peges 1 ar Department of Hea Important: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State RESI	emetery, crer JRRECT	isition (Name of matory or other p ION CEMI	ETERY 2/	the state of the s	CLIN	TON, MA	RYLAND
Deparmit Depart Impor		21. Sign Jury of Funeral Service Linese	Cohinson	2	205 S.	SHIRLI	PEYTON I	D. A		
Physician /Medical Examiner		23a Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deatle cause on each line. METAS TA Due to (or as a conseq	71/C					1 A	Approximate Interval Between Onset and Death
ate be executed hysicien and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq							
that the death certificate ob by the attending physical detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 [Ectopic pregna Other (specify)			2	23d. Date of deli Month	very Day Year
v 8 2 8	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause	given in Part I.				the cause of death?
The law ate has b	Completed						1 ☐ Yes	rmed? 20 No	prior to c death?	opsy findings available ompletion of cause of
Thys This	To Be	1 105 213/110		ER/Outpatier	IL SEL DOA	Other: 4 - Nursing	Death (Check only of Home 5 ☐ Resid	dence 6		ify)
ding h. After fune	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	njury at Vork? □ Yes 2 □ No	28d. Describe			
To the Hospitel or Attention within 24 hours after deal To the Funeral Director: completely filled in by the	O	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	v) 			City or Tov	vn, State,)	ral Route Number,
ne Hosp n 24 hou ne Fune pletely fi	edical	29a. Certifier (Check only one)	ician: To the best of my kno ler: On the basis of examina and manner stated.	wledge, deatl tion and/or in	n occurred at the vestigation, in m	s time, date and pla y opinion, death oc	ace, and due to the courred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To the To the Comp	M	29b. Signature and title of certifier	U		29c. Lice	S3885		29d. Date	e signed (Month	, Day, Year)
		30. Name and address of person who co	,	23a) (Type,	Print) A775	1720 #	307 Cc	in Ta	~ M	2022
Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 5 2004	32. Registrar's Signa			- 11	, ,			7 7 17

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 Feb. 1636 М Sharon Chamberlayne - Snell /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** P.G. Cheverly Prince Georges Gen. Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
N • Y • 5. Social Security Number **Funeral** Hours 1□M 2₩F 088-38-2009 Director 55 7/1948 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or itams 23e or 28e-f ehow any injury or other traumatic event, it a Medical Exactivar must be routlled at once. Temple Hills 1 Yes 2 No P.G. **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20748 U.S.A. 3464 Brinkley Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: Specify: Black þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Telephone Repair 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Holloway James Glover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Temple Hills, MD. 20748 3464 Brinkley RD. Jerel Chamberlayne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Valhalla, NY Kensico Cemetery 2/22/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges and Edwards 3910 Silver Hill RD.Suitland, MD.20746 Course 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final **Physician** disease or condition resulting in death) Cerebral Vascular Accident weeks /Medical Due to (or as e consequence of): Examiner years Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical attending phy IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 2 🗆 No be detached o 9 Unknown 9 Unknown signed by Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown <u>Diabetes Mellitus</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ∏Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check one) and manner stated and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu D41276 February 25, Paul Michael Wilson MD 20746 7aca 31. Date filed (Month, Day, Year) State FEB 2 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician 2004 February 8:30 AM Denise R. Cunningham-Cooper /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Prince George's Hvattsville St. Thomas More Nursing Home If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Feb. 26, 1963 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 XF 40 Wash., Director 578-92-7170 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23e or 28e-f ahov the Medical Examiner I. ust be nutified at Takoma Park 1 XYes 2 No Maryland Montgomery Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 United States 7610 Maple Ave., #803 Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Black. ۾ 3 ☑ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 21/2 Beautician Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health end Mental Important: If item 27 Is marked of Iliene M. Stewart Frederick Douglas Cunningham 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 1168 First St., N.W. Wash., DC 20001 Iliene M. Cunningham - Mother 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 2/24/04 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** unodelgitency VIVUS Syndrome /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner attending physician and I for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): cate has been signed by the a page 2 should be detached? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 🌠 Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: after death. Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 atural 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours at To the Funerel D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Yeer) DO185 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 4203 Queens bury Rd Hyattrille MD 20781 1) E /DRE MD 31. Date filed (Month, Day, 7

Registrar DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** FEBRUARY 21, 2004 1:57 AM HILDA LEE DUNNOCK /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | NOV • 20 , 1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 M 200 MARYLAND 79 220-16-3085 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show d other than "natural", or items 23s or 28s-f shovevent, the Medical Examinar must be modified at 1 YesXX No PHOENIX BALTIMORE MARYLAND Directo the 10f. Zip Code 21131 10g. Citizen of What Country?
UNITED STATES 10e. Street and Number With 3121 PAPER MILL ROAD Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status fited within 72 hours after Hygiene. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY/RECEPTIONIST COUNTY HEALTH DEPT permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Importent: If item 27 is marked other the any injury or other traumatic event, IT and 2002. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be ETHEL MERRILL LOWE ROBERT LEE LONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2249 SPANGLER ROAD, SEVEN VALLEYS, PA 17360 THOMAS L. DUNNOCK/SON Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition ST. JOHN (LETSTERS) LUTHERAN CEMETERY 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 2/24/04 WESTMINSTER, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A.
91 WILLIS STREET, WESTMINSTER, MD 22. Name and Address of 21157 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE CHRONIC OBSTRUCTIVE /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit FAILURE TO THRIVE Due to (or as a consequence of) Box 68760 ician/Medicai YEARS PULMONARY DISEASE IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month ō 4 Pregnant at time of death 5 Other (specify) ed by the a o Physi 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 XYes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy 1 Yes 2 No 2 No :: After this certification of funeral director, i Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier vallo D25886 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) ILIA CEBALLOS, M. 7801 OSLER DRIVE. TOWSON, MARYLAND 21204 D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 2 3 2004

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month February 22, 2004 7:27 am Dottie L. Demmon 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Columbia Howard Somerford Place orth (av. Year)
17,1928 Indiana If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Days Months Hours Min. 1□ M 2X F 306-24-3700 75 Sept. Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Highland Maryland Howard 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 20777 6761 Cortina Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo Specify.White If Yes, Give Yeer or Detes Specify 3\(\text{O}\)Widowed 4 \(\D\) Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Education 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Emma Faye Whipple George Leavell 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6761 Cortina Drive Highland, Maryland 20777 Diane Mortazavi/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Feb.23. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2004 Odenton, Maryland 21. Signature of Funeral Service License 22. Name and Address of Fecility
Going Home Cremation Service P.O. Box 784 Krotte MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as e consequence of): Immediate Ceuse (Final diseese or condition resulting in deeth)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

2

Completed

Be

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 2 any highly or other traumatic event, the Medical Experience 23a or 2 any highly or other traumatic event, the Medical Experience 23a or 2 and 26 and 25 and 2

Saltimore, Maryland 21215-0036

the Merylenc

Examiner Physician/Medical þ Completed Be 2

The law requires that the death certificate be executed ettending physician end for use es the buriel-trer Division of Vital Records, P.O. Box 68760, been signed by the e should be deteched After this certificete hes funeral director, page 2. To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certifice Certification: filled in by

edicai completely Registrar

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 ☐ Yes 2√ No 27. Menner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature, end title of pertifier

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. KINSONISM 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28b. Time of 5 Pending investigetion

28c. Injury et Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rurel Route Number, City or Town, State) **XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

23h. Did tobacco use contribute to the cause of death?

1 Yes 2 2NO

1 Yes 2 No

24a. Wes en autopsy performed?

Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Living

28d. Describe how injury occurred

Musgrove Rd # 105 Silver Spring, MB

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

February 23, 2004

2004

31. Dete filed (Month, Dey, Year) **FEB 24**

6 Could not be determined

's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 07556 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month D. February **Physician** Raynor Calvin 2004 2:35 P™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Yrs. 61 213-42-5754 Director November 26, 1942 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28e-f show the Medical Examinar roust by putilised at 10d. Inside City Limits 1 XYes 2 □ No Directo Maryland St. Mary's Leonardtown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 41720 Milepost Lane 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Instructor Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Calvin Herbert Dean Dorothy Virginia Weddle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Dean / Wife P.O. Box 2355 Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State February 4 □ Donation 5 □ Other (Specify) Charles Memorial Gardens 9, 2004 Leonardtown, Maryland 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 21. Signature of Funeral Service License tardener uchaels 23a. Part I Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ٤ /Medical Due to (or as a c na uence Examiner Sequentially list conditions, any learned immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consucusnos attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) ed by the 9□ Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1☐ Yes 2 No Hospital or Attending Physician: filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4® Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 1 😭 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Staminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner styled. (Check only one) To the within 2 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 1020 30. Name and address of pe on who completed cause of death (Item 23a) (Type, Print) <u>/2/4035 Three Notch Road, Hollywood, MD 20636</u> Patrick J. Darboe, MD rar's Signature 2004 Registrar

1 Decedent's I

Please Type or Print in Bla	ack Indelible Ink. Ensure Al			
State of Maryland	/ Department of Health and M Certificate of Death	Mental Hygid Reg	ene 2004	07557
Name (First, Middle, Last) rancis Joseph Dearstine		2. Date of Death		3. Time of Death
ne (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	

/Medical Examiner

Physician

Funeral Director show event, the Medical Examiner must be notified at 28a-f Direct the ŏ 238 Funeral death or items Completed by natural Be 2

if Health and Mental Hygiene.

itled within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Warren Lee Dearstine 19a. Informant's Name/Relationship (Type, Print) 20a, Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed the burial-transil and Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical use as IF FEMALE 23b. Was decedent pregnant ρ in the past 12 months? 4☐Pregnant at time of death P.O. I the ☐Yes 2☐No 9 Unknown 9 Unknown signed by 1 d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ Completed been page Physician: ector. 25. Was case referred to medical examiner? Be 1 XYes 2 No 2 this 27. Manner of Death Certification: After Attending 5 Pending investigation 1 Natural death. 2 Accident the f within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 4 ☐ Homicide filled in by ŏ RESIDENZE Hospital 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier

F 4a. Facility Nar 26252 South Sandgates Road Mechanicsville St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 1 ★M 2 F 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Davs Hours 212-54-1637 55 December 20,1948 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 20659 26252 South Sandgates Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc 1 Never Married 2 Married 1□Yes 2XNo Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Painter Painting 18. Mother's Name (First, Middle, Maiden Sumame) Agnes Bertha Grabis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly D. Russell/Daughter 24462 Coltons Point Road, Clements, MD 20624 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory 2/6/2004 Alexandria, Virginia 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Mattingley-Gardiner Funeral Home, P.0. Box 270, Leonardtown, Maryland P.0. Box 270, Leonardtown, Maryland Shock, or heart failure. List only one cause on each line. P.O. Box 270, Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death OF CMEST CONTACT BUNSHOT WOUND Due to (or as a consequence of) Due to (or as a consequence of)

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown

Year

HO

24a. Was an autopsy performed? 1⊠Yes 2□No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 2/2/04 (FOIND) FOUND 9:05/M

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred SUBJECT SVLOT SELF 28f. Location (Street and Number or Rural Route Number, City or Town, State)

26252 S. SANDGATES RD, HECHANICSVILLE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Sther (Specify) At SCENE

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) February 03, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA RUBIO, MD 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registra

FEB 0 5 2004



State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 17, 2004 **Physician** Kenneth Dyson, Sr. James 3:30 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Charlotte Hall Veterans Center Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Hours 1**⊠** M 2□ F 86 Feb 6, 1918 Maryland Director 216-14-5734 Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Lusby Calvert Funeral Director the the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 20657 11435 Stirrup Lane USA Items 23a death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event. The Mustical Essenti 1 Yes 2 No If Yes, Give 1941-46 Year or Dates: 1 ☐ Never Married 2 🔀 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dyson Frances Downs Phillip 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11435 Stirrup Lane Lusby, MD 20657 Sophie E. Dyson (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 21 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 Southern Mem. Grdns Dunkirk, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Service Licensee.... 22. Name and Address of Facility Lee Funeral Home Calvert, PA pnce Þ 8125 Southern Maryland Blvd. Owings, MD 20736 Gary J. Goff 23a. Pert1. Enter the disease, or obmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Hepatic Encephelopathy
Due 10 (or as a consequence of): Physician resulting in death) /Medical Liver Cirrobsis **Examiner** Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the turneral director, page 2 should be detached for use as the burial-transit completely filled in by the turneral director, page 2 should be detached for use as the burial-transit resulting in death) Last P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was en autopsy 22 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2XNo 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of D45092 30. Name and a ess of person who completed cause of death (Item 23a) (Type, Print) 10+1 110 Hospital Road Parul Jani, MD Ste 303 Prince Frederick, MD 31. Date filed (Month, Day, Year) 32. Registras Signature State FEB 20 2004▶ Registrar

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1	35		Alain G. C	ham pak	00 × V	UD. FIRE	(pper V	Vau (bo	NO N	NO !	2004
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1		*				
	Registr	ar	FEB 2 4	2004	ve St.	Spe						

State of Maryland / Department of Health and Mental Hygiene 2 [] 1 [] For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 3:47 PM **Physician** Davis Feb 19 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ **X**4X2 □ F 220 58 8049 Director 49 Nov 26. 1954 Washington DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits is 23a or 28a-f show 10a, State 28a-f show 1 Tes 2 700 Director MD Prince George Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 9721 Old Frank Tippett Road United States Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M Yo ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian TIBUTE Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 Maryland 21215-0036 1 Yes 2 No Specify: the Mudical Exter 3 ☐ Widowed 4 ☐ Divorced B1ack "natural", 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US POst office 12 other Department of Health and Mental Hyg Important: if item 27 Is marked other any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be pe Robert Davis Dorothy Brown Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9721 Old Frank Tippett Road, Upper Marlboro. Gale Sumner Davis (Wife) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Berial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State * 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery Feb 24, 2004 Clinton, Maryland 21. Signature of Funeral Service Licensee permil. 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, Maryland 20735 M005 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine transit-The law requires that the death certificate be executed physician ar resulting in death) Last .O. Box 68760, c Cardiovascular Diseas Physician/Medical as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy ō Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ď. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 ☐ Probably 4 🛣 Unknown 1 ☐ Yes 2 ☐ No peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No certificate 2 No 1 Tyes Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical examiner? ector Be 26. Place of Death (Check only one) Hospital: 1 __Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 🛣 lo d ဥ 2 Lly R/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide t 24 hours aft e Funeral Di letely filled in 1 Xxertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Feb 20, 2004 30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Uma Prasad, M.D. 31. Date filed (Month, Day, Year)

FEB 24

2004

32. Pagistrar's Signature

2100 West Penn Ave, North East, Washington DC 20037

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			Registrar UIII 1 LEUF 2.3 Decedent's Name (First, Middle, Last,		111,002092	7.200		2. Date of Deat	th	3. Time of Death
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	Examin	er							Washi	naton
			Washington County 5. Social Security Number 6. Security		rs. last birthday)	If Under 1 Year		s. 8. Date of Birth	9	Birthplace (State or Foreign
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Division	of or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, st	-		28f. Location (S	treet and Number o	Rural Route Number,
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N	X		30. Name and address of person who of	ompleted bause of death (Item 23a) (Type 111	Print) Penn St	reet. Ba	ltimore,	Marvland	21201
1			S. K., TUGT.	32. Registrar's S					4	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 18 2	104 Delesar		serth				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** FEBRUARY 15 12:18A M 2004 DIXIE LEE DAVIS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON HOMEWOOD RETIREMENT CENTER WILLIAMSPORT if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕅 F Yrs MARYLAND MARCH 6, 1937 Director 214-34**-**93<u>43</u> 66 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner nated by collising at 1 ☐ Yes 2 No Director CLEAR SPRING MARYLAND WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 14353 NATIONAL PIKE 21722U.S.A. or Itams 23a death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify ð 3 X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARRY ALBERT WILHIDE SR. HAZEL MATILDA GORDON ဨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY L. DAVIS/SON 11286 CROFTON CIRCLE, WAYNESBORO, PA 17268 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Its
eny injury or ott
once. 1 XBurial 2 ☐ Cremation 3 Removal from State 5 Other (Spepify) FAIRVIEW CEMETERY 2/18/2004 ' 4 Donation KEEDYSVILLE, MARYLAND 22. Name and Address of Facility 21. Signature of Fur 7606 Old National Pike BAST FUNERAL HOME Paul m. Dean Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death 23a. Park. Enter the disease, by complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final WUTE **Physician** disease or condition resulting in death) /Medical (gras a consequence Due to **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.O. the be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not is sulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 N.No. 3 ☐ Probably 4 ☐ Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 1 ☐ Yes 2 ☐ No certificate ENMILL TION CURA or Attending Physician: Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 2 3□ DOA 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 27. Magner of Death After 1 Natural 2 Accident Injury 5 Pending 1 🗌 Yes 2 🗆 No within 24 hours after death.

To the Funerel Director: A
completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check ont) one) 29c. License number 29d. Date signed (Month, Dav. Year, 29b. Signati EDICA 1atera 54 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of Megistrar's Signature ZNEN 32. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 07563 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month ELIZABETH DRYDEN DAVIDSON 02 2004 1:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7847 Public Landing Road Snow Hill Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2**X**F Yrs. 192-12-5380 06/22/1924 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Worcester Snow Hill 1 ☐ Yes 2 ZNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7847 Public Landing Road 21863 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Edgar Dryden Margaret Ann Henman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. Davidson (son) 202 W. Martin St., Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 2/25/2004 Salisbury, Maryland 21 Signature of Fun II Service Licensee 22. Name and Address of Facility Muhrel Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) on ovary Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate saude. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2**X** No

Physician /Medical Examiner

Physician

/Medical

Directo

Funeral

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Completed

Be ဥ 10a State

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at

the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

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item 27 i

Department of H Important: If ite any injury or ot once.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit been signed by the should be detached certificate Physician: this funeral After death. lospital or Attendi 4 hours after death. •unaral Diractor; A filled in by the

requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Physician/Medical 2 Certification:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🗌 Yes 27. Manner of ath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

1 Natural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifie

Hene

29a. Certifier

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D38353

29d. Date signed (Month, Day, Year) 2/23/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 Eastern Store Dr. Salisbury, M. 21804

State Registrar 31. Date filed (Month, Day, Year) FEB 2 3 2004

Desmarais

32. Refistrar's Signature

within 24 hours a

			1 - For State Registrar	State of Man	yland / Depa <i>Cei</i>	artmeni rtificate	t of Heal	th and Nath	lental Hyg	iene 20	04 07565	5
	Physici		1. Decedent's Name (First, Middle, Las Gary Kenneth Dani						2. Date of Death Month February	Day Ye	9ar 4 1 • 17 Δ	
	/Medic Examin		4e. Fecility Name (If not institution, give	street and number)			Town, or Loca	tion of Death	remuary	4c. County of I	Death	
	uneral irector		Montgomery Genera 5. Social Security Number 6. Security Number 10	x 7. Age (I STM 2 ☐ F	n yrs. last birthday) Yrs.	If Under Months		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day,	Year)	nery Birthplace (State or Foreign Country) Alahama	
P			Usual Residence of Decedent 10a. State 10b. County		0c. City, Town or Lo	cation			Feb.14,1	950 F	10d. Inside City Limits	_
тье Мал	28a-f sh notified	Director	Maryland Montgome	ry	01:	ney 10f. Zip	Code		10	Og. Citizen of Wha	1 ☐ Yes 2 ☐ No	
G Z I Z I 3-0030 filed within 72 hours after death with the Maryland	Department of result and wenter trylines. Department of result and wenter trylines. Department if them 27 is marked other than "natural", or theme 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once.	Funeral Dir	17420 Cherokee La 11. Marital Status 1 □ Never Married 2⊠ Married	12. Was Decedent Eve	er in U.S. 13.		20832		ecify Yes or No- Rican, etc.)	USA 14. Race -	American Indian, White, etc.	_
hours af	tural', or	by	3 Widowed 4 Divorced	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give 1 9 Year or Dates:	19/4	1 ☐ Yes 2	No Spe	ecify:		Specify:	White	_
within 72	then "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of wor DO NOT us	k done during e retired)		ring			
be filed	od other	Be	17. Father's Name (First, Middle, Last)	2	Rural	Route	e Carri		e (First, Middle, M		stal Service	
2 should	and Mer is marke sumatic	T ₀	Truman Knox Danie 19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address	(Street and N		aret Shar al Route Number,		te, Zip Code)	_
38 1 and	item 27		Cindy L. Daniel 20a. Method of Disposition 1 □ Burial 2 【▼Cremation 3 □		17420 20b. Place of Disponsion Commeterly, crem	sition (Nam	rokee I		Olney, M	Iaryland 20c. Location - City	20832 y or Town, Stete	
permit. Pages	ortant: Il		*4 Donation 5 Other (Specify, 21. Signature of Funeral Service License)	Metropol:	Crer	d Address of F	acility			La,Virginia	_
Ď ž			Brofley 2 23a. Part 1. Enter the disease, or comp	me fet	5(00 Un:	iversit	y Blvc	Funeral	ver Spri	nc. ing,MD 20901 Approximate	_
*/N	ysician ledical		shock, or head failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne čause on each line.	Bleeding		, 3 .				Interval Between Onset and Death	
, Act	aminer	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Alcoholi Due to (ur as a c	c Cirrhos ansequence of).	sis						
The law requires that the death certificate be executed	ohysician and the burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):							
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the death	ed by the attending pl detached for use as t	hysician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown		Ectopic pre Other (spe				Month	Day Year	
requires that	සි අ	by P	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	nderlying ca	tuse given in F	Part I.			te to the cause of death? Probably 4 □Unknown	
ian: The law re	certificate has been si rector, page 2 should	Completed			177				24a. Was an autopsy perform	prior ed? deat No 1□	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \) No	-
OI VIII Physicia	n. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1気 Inpatient	2 ER/Outpatien		A Other: 4[h <i>(Check only one</i> me 5 ☐ Resider		Specify)	
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ital or At	within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Certif	4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory	, office		28f. Location (Str. City or Town,	eet and Number o State)	r Rural Route Number,	
the Hosp	Within 24 hours and To the Funeral Dir completely filled in	ledical	(Check only 2 Medicel Exam	sicien: To the best of n iner: On the basis of ex and manner stated	amination and/or inv	vestigation,	in my opinion,	death occur	red at the time, da	te and place, and	due to the cause(s)	
2	# 2 5 1	Σ	296. Signature and title of certifier	Sittle	no	29c.	License num			d. Date signed (M		
1			30. Name and address of person who co James Butler, M.D			Print)				·		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 23 200	32. Hegistrar's		1	els/	ollver	Spring,	MD 2090	11	

			1 - State Registrar	State of M	aryland / l	Department Certificate	t of Health e <i>of Death</i>	and Mental	Hygien	e2004	07566
	Physici		Decedent's Name (First, Middle, Last)	Celi	a DAVID	SON		2. Date Monti Febr	n D	year 20, 2004	3. Time of Death 9:45 P M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City,	Town, or Location			c. County of Deeth	
			Hebrew Home of G	reater Wa	shington		ckville			Montgom	
	Funeral Director		5. Social Security Number 6. Security Number 1 5. S	7. Ag	ge (In yrs. last bii 85	rthday) If Under Yrs. Months	1 Year If Under Days Hours	Min. 8. Date (Mont	of Birth h, Day, Yea 3, 191	r) 9. Birth Cou 18 New	place (State or Foreign htry) York
	put		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
	faryla sho	ō									1 ☐ Yes 2 ☐ No
	288-	Director	Maryland Montgor 10e. Street and Number	nery	K	ockville 10f. Zip	Code		10g. C	Citizen of What Cou	ntry?
	3e or		6121 Montrose Road				20852			United S	tates
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Deced	ent of Hispanic O	origin? (Specify Yes an, Puerto Rican, etc	or No-	14. Race - Ameri Black, White,	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23e or 28s-1 show remaite event, the Madical Executes than he inclined at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 21 If Yes, Give Year or Dates:		1 ☐ Yes 2			,	Specify:	
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	od will gjene er the	Com	12			Home	emaker			Own Ho	ne
pu	be filed ital Hygid od other event, II	Be	17. Father's Name (First, Middle, Last)				18. Moti	her's Name <i>(First, M</i> Dora Ko		en Surname)	
Z	should ind Men ind Men ind marke	ပ္	Edward Schee:		101	Mailing Address	(Street and Num	ber or Rural Route N		os Tourn State Zie	Codel
Maryland	ond 2 shall hand 27 is n		Doreen Davidson,					d., Bethe			Code
ē,	Hea item othe		20a. Method of Disposition		cemete	of Disposition (Namery, crematory or or	ne of ther place)	02/22904	20c.	Location - City or To	own, State
Ē	Page Time D		1 M Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		David Men		arden	Fa1	.1s Churc	n, VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23e or 28s-1 show any injury or other traumatic event, it a Marileal Exercities to any injury or other traumatic event, it a Marileal Exercities to any once.		21. Signature of Funeral Service Licens	99				rew Funera			20012
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that cause	d the death. Do	not enter the mode	e of dying, such a	is cardiac or respirat	ory arrest,	, , ,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Mult	i-infa	1 /	ementio	d			Onset and Death
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e	LXammer	10	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	of):					
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9	ertific ding pl		IF FEMALE:	12a If was outcome	of programmy						
Вох	that the death certified by the attending detached for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome 1□Live birth 4□Pregnant a	2 Fetal death	3 ☐Ectopic pro				23d. Date of deliv Month	ery Day Year
o.	the de y the ached	ysic	1 Yes 2 No 9 Unknown	9□ Unknown		0 0 0 0 110 / (9)0					
<u>α</u>	The law requires that the death certifite has been signed by the attending lage 2 should be detached for use as	by Pl	Part II. Other significant conditions co	ntributing to death t	out not resulting	in the underlying ca	ause given in Part	t I. 23e.	Did tobacco	use contribute to t	he cause of death?
ord	w require been sig should b	ted			.				1 Yes	2 No 3 □ Proi	oably 4 Unknown
Records,	law range has be	Completed							Was an autopsy	prior to co	psy findings available impletion of cause of
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Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	ce of Death (Check			
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ion	Attending I r death. ector: Alter by the funer	atior	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	ly Year)	Injury M	Work? 1 ☐ Yes 2 [□No			
Division	after des Director in by th	ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At home, fa tc. (Specify)	arm, street, factory	, office		ion (Street a or Town, Sta	and Number or Rura te)	al Route Number,
_	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical Certification:			of examination at			and place, and due to eath occurred at the			
	To the within 2 To the complex	Mec	29b. Signature and title of certifier		in	/ ₂ (7 29c	. License number		29d. D	ate signed (Month,	
			I fatricia lo	mske!	May, 1.	most	D5191	6'	Fe	bruary	21,2004
	(0		30. Name and address of person who co	ompleted cause of	death (Item 23a)	(Type, Print)	2000	Dadd F	In La	:11 mi	21, 2004
	CA	ata.	31. Date filed (Month, Day, Year)	32. Begist	rar's Signature	MONTY	ase r	vuy M	JULV	1116, 111	XVOVX
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		1 - For State Registrar	State of Marylar	nd / Depa	artment rtificate	of H	ealth ar Death			Reg. No. 4	004	0756
Physic	cian	Decedent's Name (First, Middle, Lass						ŀ	Date of De. Month	ath Day	Yeer	3. Time of Death
/Med		S. SONTA	DAVIS						FEBRUA	RY 21,		10 30 P M
Exam	iner	4a. Fecility Name (If not institution, give					Location of C	Death			ty of Deeth	
		5. Social Security Number 6. Sec		last hirthday)	ROCK		ff Under 24	Hrs.	8 Date of Bird		TGOME	
Funera Directo			□ M 2□ F 81	Yrs.		Days		Min.	8. Date of Bird (Month, Da JULY 6	y, Year) 1922	GERM	olace (State or Foreign ntry) ANY
a Maryland a-f show	ctor	10a. State 10b. County MARYLAND MONTGOM		ity, Town or Lo							1	0d. Inside City Limits 1 Tyes 2 No
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ath wi		12530 HIALEAH WAY			2	2087	8			UNITED	STAT	ES
within 72 hours after death with the Maryland jiene. rihan "natural", or Itama 23a or 28a-f show the Marilcel Eraminer must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 TWidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates:		1 ☐ Yes 2	X No	Specify:	n? (Spec Puerto R	ify Yes or No lican, etc.)	Speci		etc. VHITE
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s 1 and the all the missing th		MARGOT DAVIS MONGO 20a. Method of Disposition 1 XBurial 2 Cremation 3	20b. I	12530 Place of Dispo cemetery, crer	sition (Name	of	Ī	Da	OTOMAC .	20c. Location	0878 - City or To	wn, State
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permit. Pages 1 a Department of Hee Important: If them any injury of otha		21. Signatur of Fulleral Sovice Licen	h. Jon						DIREC		INC.	0852
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requires that een signed b	b	Part II. Other significent conditions co	entributing to death but not res	sulting in the u	nderlying car	ise giver	in Part I.			obacco use cor		e cause of death?
The law ate has b	Completed								24a. Was autop perfor 1 Yes	SV	prior to con death?	osy findings available inpletion of cause of 2 No
ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Unanital.			1		Death (Check only o	ne)	-22	
ding Phys h. After this	ation: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		. Injury : Work?	4 A Nursin	_		lence 6 Otl ow infury occu		")
al or Attanding s after death. In Director: After the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory,	office		28	ff. Location (S City or Tow		ber or Rurai	Route Number,
To the Hospital or Attan Within 24 hours after deat To the Funaral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exam	/sician: To the best of my kno inar: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at vestigation, i	the time	, date and p nion, death o	place, an	d due to the o	cause(s) and m date and place,	anner as sta	ated. the cause(s)
To the To the Complete	Me	29b. Signature and title of certifier	0		29c.	License	number		2	29d. Date signe	ed (Month, L	Day, Year)
15		> duomus	V. Susepl			4733	0			FEBRUAF	RY 23	2004
		30. Name and address of person who c				***	11000	Do:			00050	
	ate	THOMAS V. JOSEPH 31. Date filed (Month, Day, Year)	M D 50 W R	DMONST	-		<u>#207</u>	KOC	CKALTTE	E_MD	<u> 20852 </u>	
Regis		FEB 242	E .		Sp	arks.						

State of Maryland / Department of Health and Mental Hygiene For State Registrar 07568 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 10:47am **Physician** Ebruary Dean A. Denny 19 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Maryland Medical System Baltimore University of , maryland If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 12XM 2□F Director 578-56-4655 86 Dec. 16, 1917 Kansas Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h. County ral, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 217 No Director Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 4801 Laguna Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 [XYes 2 No 1941— 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iten any injury or other traumatic event, the Medical Evantrial and e. . Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 1952 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Off-set Printer Federal Printing Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Irving Denny Ada Shippy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Denny Wife 4801 Laguna Road College Park, Marvland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln

Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Feb. 26, 2004 Brentwood, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -aryngeal /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient c 3□ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Contrey Resertel, no skesident Physician 9,2004 K1526 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) MP 2120 Coursey Rosenthal St. Balhonore 22 S. Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 24 2004 Registrar

			For State Registrar	State of M	larylan		artment o				Reg. No 2	04	07569
	Physici	an	Decedent's Name (First, Middle, MILTON AMISS	Last) DOFFLEMYER						2. Date of Oe.	ath Iry 19	Year	3. Time of Death
	/Medic	al	MILTON AMISS 4a. Fecility Name (If not institution,				4b. City, Tow	n, or Location	of Death	rebrua		2004 ity of Death	2:45 A ^M
	Examin	er	Casey House, M	-		ee		ville			Mont	gomer	J
	Funeral Director		224-16-9207	6. Sex 7. A	ige (In yrs. 82	last birthday) Yrs.	If Under 1 Ye Months Da	ear If Under ys Hours	r 24 Hrs. Min.	8. Date of Bir (Month, De July 1	th y, Year) 6, 1921	Cou	olece (State or Foreign ntry) inia
	land ow		Usual Residence of Decedent 10a, State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limits
	e-f sh	ctor	Maryland Montgo	mery	12	324 Ta	mpico W	lay					1 X Yes 2 □ No
	vith the	Funeral Director	10e. Street and Number 12324 Tampico	Max			10f. Zip Cod	^{le} 0904			U.S.A		ntry?
	eath v	eral	11. Marital Status		t Ever in U.	S. 13.			rigin? (Sp	ecify Yes or No		ece - Ameri	can Indian,
920	i within 72 hours after death with the Maryland liene. I than "natural", or items 23a or 28e-f show the Medical Examiner must be mailfied at	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces ed 1 ∑Yes 2 ☐ If Yes, Give Year or Dates	No to		If Yes, specify (ecify Yes or No Rican, etc.)	1	lack, White, sify: Whi	
2-0	72 ho 'natur	eted	15. Decedent' (Specify only highest			16a. Dece	dent's Usual Oc kind of work do	ne during mo	st of work	ing	16b. Kind of		•
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 2 Years	r 5+)		<i>DO NOT</i> use re irefigh				Distri Fire D		Columbia
d 2	Hyger the	0	17. Father's Name (First, Middle, L	1		I	riciigi		ner's Nam	e (First, Middle,			ment
/lan	should be and Mental marked o	ToB	Milton Amos Do	offlemyer				Nao	mi F	razier			
Maryland	and and list m		19a. Informant's Name/Relationsh							al Route Numbe			
di.	1 and Health em 27	1	Alan Dofflemyer 20a, Method of Disposition	r/Son	20b. P	lace of Dispo	sition (Name o	1		Date	ing Ma		nd 20904 own, Stete
TOL	ages ent of th: ##		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		9 [matory or other s Episc			4/2004 Ceme.	Silve	r Spri	ng, MD
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or of		21. Signature of Funeral Service L		tie	H ²	Name and AC	Idress of Faci	UNER	AL HOME Avenue	, INC.	er Snr	20904
F			23a. Pert1. Enter the disease, or shock, or heart failure.	complications that cause	ed the deet							JI OPI	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Debili								1	Onset and Death ess 1 Month
	/Medical Examiner		resulting in death)	Due to (or a									
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	be executed sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	c	s a consequ	neuce of):	-						
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89	leath certifical attending phy I for use as th	Med	IF FEMALE:	23c. If yes, outcom	a of propaga								
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9	es that igned b be deta	by Pt	Part II. Other significant condition Advanced Dem		but not res	ulting in the u	nderlying cause	given in Part	1.				ne cause of death?
ord	v requir been si should	eted	Havaneed Bell							V			pably 4 □Unknown
Records,	The law cate has t page 2 s	ompleted									rmed?	prior to co death?	psy findings available mpletion of cause of
Vital		e C	25. Was case referred to medical					26. Plac	e of Deat	1 ☐ Yes		1 🗆 Yes	2 No
of V	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 Inpa		ER/Outpaties	" JU DOY			me 5 🗆 Resid			y) Hospice
	After	:lon:	27. Manner of Death 1 ⊠Natural 5 □ Pending		jury Jay Year)	28b. Time o Injury		njury at Work? 1 ☐ Yes 2 ☐		28d. Describe	now injury occi	urred	
Division	deat deat ctor: / the	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of li	njury - At ho	ome, farm, st			1110			nber or Rura	al Route Number,
Ö	- e -	Cert	4 Homicide	bullaing, (atc. (Specifi	y) 				City or Tov	vn, State)		
	To the Hospital of within 24 hours at You the Funeral D completely filled in	edical	29a. Certifier 1 ☑ Certifyin: (Check only 2 ☐ Medical E	p Physician: To the bes Examiner: On the basis and manner:	of examina stated.	wledge, deat tion and/or in	h occurred at th vestigation, in n	e time, date a ny opinion, de	nd place, ath occur	and due to the red at the time,	cause(s) and r date and place	manner as s e, and due to	tated. the cause(s)
	within Fo th compl	Me	29b. Signature and title of certifier	2010			29c. Lic	ense number			29d. Date sign	ned (Month,	Dey, Year)
	5		Class	the			C	00	412	118	2/2	19/0)4
			30. Name and address of person of Charles Harris	who completed cause of	death (Item uncast	123a)(Type, ter Mi	Print) 11 Road	/ /	,		and 20	852	1
	Sta Registi		31. Date filed (Month, Dey, Year) FEB 2 3	32. Begis	strar's Signa		Span						

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			1 - For State Registrar		5	State of	Mary	land / De <i>C</i>	partmei e <i>rtifica</i>				lental H	_	ne vo. 2 (nı.	0.7	570
			Decedent's Nam	тө (First, Midd	le, Last)				57111104				2. Date of D	eath			3. Time	of Death
	Physici /Medic		Geor	ge Dra	acke	tt							Month 0.2		0 ay	Year 2004	8:	45am
	Examin		4a. Fecility Name (nber)				r Location		4c. County of Dea					
_			Holy C		Hospi 6. Sex		7. Age (In	yrs. last birthda	_	ollVer 1 Year	er S	prir	R Date of Right					e or Foreign
ě	Funeral Director		218-29-4			2□F	78	Yrs.	Months		Hours	Min.	06/0	Dev. Yee	9°25	Jai	naic	te or Foreign a
	pu .		Usuel Residence of	f Decedent 10b. County	,		100	: City, Town or	Location									City Limits
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	23a o 23a o ust be	raiD	3000	McCom	nas A	ve				2089	95				Bri	tiai	n	
	ftems	unei	11. Marital Status			Was Dece	rces?	in U.S. 1	3. Was Dece ff Yes, sp	edent of H ecify Cuba	lispanic Oi an, Mexica	rigin? (Spi in, Puerto	ecify Yes or N Rican, etc.)	10-		ce - Ameri ck, Whife,		,
336	urs aft	by F	1 ☐ Never Man 3 ☐Widowed	_		1 ☐ Yes If Yes, Giv Year or Da	θ -		1 🗆 Yes	2 ☑ No	Specity	<i>c</i> :			Specif	y: Bla	ck	
2-0	filed within 72 hours after death with the Maryland Hygiene ther then "natural", or flems 23s or 28s-1 ehow ther then "natural", or flems 23s or 28s-1 ehow ont, the Medical Exertimetr usal be medified at	Completed	(Spe	15. Deceder				(G	cedent's Usi	onk done i	during mo.	st of work	ina	16b.	Kind of B	lusiness/In	dustry	
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Maryland 21215-0036	2 short and N le ma	8	19a. Informant's N				`						Al Route Num		y or Town, 832	, State, Zip	Code)	
e, r	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show minimal injury or other traumatic event, the Modical Exercities as the notified at ance.		Judith 1		(Dau	ghter		Ob. Place of Dis			1		Date			- City or To	own State	
nor	ages ont of fir. If it			□ Cremation		noval from S			rematory or	other place	ce)		9,2004			ale,		
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ã	80 E 8			went 5	Jugar.	T							Cremat N.W. V		ingto	on, D		
e.			23a. Part1. Enter shock, or he		complica t only one	tions that cause on ea	aused the ach line.	death. Do not i	enter the mo	de of dyin	ng, such as	s cardiac (or respiratory	arrest,			Approxin Inferval E Onset ar	nate Between nd Death
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0.	it the dea by the a tached f	ysic	1 ☐ Yes 2 9 ☐ Unknow	□No		4☐Pregna 9☐Unkno		of death	5 🗌 Other (s	specify)							,	
Q _	res that the igned by be detact	by Ph	Part II. Other sign		ions contri	buting to de	ath but no	t resulting in the	underlying	cause giv	en in Part	1.	23e. Did	tobacc	o use con	tribute to t	ne cause o	of death?
Records,	w require been sig should b	led b	Hyperten	sion									1[] Yes	2 🗆 No	3 🗌 Prot	ably 4	⊠Unknown
ecc	has be	Completed	Cerebrov	ascula:	r	Accid	ent						24a. Wa aut	opsy	24b.	Were auto	psy findin	gs available if cause of
al B			Diabetes										1□ Yes			death?	2□ No	
Vital	Physician: r this certifica ral director, i	o Be	25. Was case refe examiner? 1 ☐ Yes 2 ☑			spital: 1 🛛 Ir	npafient	2 ER/Outpat	ient 3 D	OA Oth	or.		n <i>(Check only</i> me 5 ☐ Re:		6 🖺 Ott	ner (Snecit	ivi	
Jor	ding Physician: After this certific funeral director,	H- 1	27. Manner of Dea	ith		28a. Date of				28c. Injun Worl		- 1	28d. Describe				,,	
sion	Attending or death.	catic	1 ⊠Naturaf 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pendi invest 6 ☐ Could	igation				М	1 🗆	Yes 2□							
Division		Certification:	4 Homicide	dotor		28e. Pface buildir	of finiury - ng, etc. (S	At home, farm, pecify)	sfreet, facto	ry, office			28f. Location City or To			oer or Rura	ıl Route N	umber,
_	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in		29a. Certifier	1 ☑ Certifyi	ng Physic	ian: To the	best of my	r knowledge, de	ath occurred	d at the tin	ne, date a	nd place,	and due to the	e cause	(s) and ma	anner as s	tated.	
	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one)	2 Medice	Examine	r: On the ba	asis of exa- ner stated.	mination and/or	investigatio	n, in my o	pinion, de	ath occurr	ed at the time	, date a	ind place,	and due to	the caus	Θ(S)
	To T To I	2	29b. Signature and	d title of cestifie	*\ \V 1	AA	/		29	oc. Licens	e number	10-1				id (Month,		")
7	Ü		30. Name and add	less of sand	W	J V	e of death	(Item 23a) /T	o Print'	P.	ンイン	7		Ud	-11	-20	T	
			Neeraj					9 Gaith		rg,	MD 2	20883						
	Sta		31. Date filed (Mo	nth, Day, Year	2004	32. 2	egistrar's S	Signature 4	In	aks	,							
	Regist	rar	۲	EB 24	ZUU4	10	- President	~	19	- 45-69								

			1 - For State Registrar	State of Mar		artment of rtificate of			ene g. No. 200	0757
	Physic		1. Decedent's Name (First, Middle, Last) Adam F. Dydak					2. Date of Death Month February		3. Time of Death 04 4:27A M
	/Media		4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of Dea		4c. County of De	
	ZX		1959 Seminary Road			Silve	r Spring		Montgome	ery
	Funeral Director		5. Social Security Number 6. Sex 1⊠ 11⊠	7. Age (1 83	n yrs. last birthday) Yrs.	tf Under 1 Year Months Days			9. B 1920 II	irthplece (State or Foreign Country) Linois
	and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	e Maryl Ba-f eho	ctor	Maryland Montgomer		Silver S					1 ☐ Yes 2 ₹ No
	with th	Dire	10e. Street and Number			10f. Zip Code			g. Citizen of What C	•
	s 23	erai	1959 Seminary Road	. Was Decedent Eve	-1-110 401	20910			nited Sta	
21215-0036	d within 72 hours after death with the Maryland liene. I than "naturel", or Items 23a or 28a-f ehow than Macilton Examinat runs for notified at the Medical Examinat runs for notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1 1 Yes 2 1 No If Yes, Give 19 Year or Dates:		was Decement of f Yes, specify Cul 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)	Black, Wh	
5-0	72 ho	Completed	15. Decedent's Educa (Specify only highest grade	tion completed)	16a. Deced	tent's Usual Occu	pation during most of wo	ndking 1	6b. Kind of Busines:	s/Industry
121	c * 38	mple	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	life. I	DO NOT use retire	9d)	-	entral In	telligence
2			17. Father's Name (First, Middle, Last)	1	Russ	ian Tra	nslator	ma /Circa Adiedella Ad	Ager	nt
/lanc	0 = 0 >	To Be	Jan Dyd	ak			Marce]	me (First, Middle, M Llina K	anden Sumame) Colodziejo	zyk
Maryland	d 2 sho th and 1 t7 is ma trauma		19a. Informant's Name/Relationship (Type Miriam Hass Dy	o, <i>Print)</i> dak (Wife)		g Address (Stree Seminar	t and Number or R y Rd., Si	ural Route Number. 1ver Spri	City or Town, State,	Zip Code) 20910
Baltimore,	ages 1 and of Heal		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Rei	moval from State	20b. Place of Dispo	natory or other pla		Date 21 h 8,2004 A	Oc. Location - City o	
Baltin	permit. Pages 1 and 2 should b Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic e once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Eurieral Service Licensee		22	. Name and Addr	ess of Facility	remation.		
* 1	Physician /Medical		23a. Part1: Enter the disease, or complicion shock, or heart failure. List only one timediate Cause (Final disease or condition resulting in death)	cause on each line.	of Prost	er the mode of dy	Avenue Si ing, such as cardia	_Iver_Spri	ng, MD 2	Approximate Interval Between Onset and Death 10 Years
60,	rate be executed XX hysicien and mile burial-transit	dical Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause there Underlying that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
.O. Box 6	that the death certificate ed by the attending phys detached for use as the	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	tyes, outcome of p 1 Live birth 2 C 4 Pregnant at time 9 Unknown	Fetat death 3	Ectopic pregnance Other (specify)	y		23d. Date of de Month	olivery Day Year
rds, P	sign sign d be	by	Part II. Other significant conditions contr Arteriosclerotic F			derlying cause gr	ven in Part I.			o the cause of death?
<u> </u>	The ate h page	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Vital	ysicien: Th	Be	25. Was case referred to medical examiner?	pital:		O#	200	th Check only one)		
o	ling Ph After th Iuneral	tion: To	1 Yes 2 No	1 ∐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of ar) Injury	28c. Inju. Wo	ry at	ome 5 A Resident 28d. Describe how		ecify)
5		Certification:	3 Suicide 6 Could not be determined	28e. Place of tnjury - building, etc. (S	At home, farm, stre			28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one)	ian: To the best of m r: On the basis of exa and manner stated.	y knowledge, death amination and/or inv	occurred at the tile estigation, in my o	me, date and place opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To the Within To the comple	Me	29b. Signature and title of certifie	1 0	1	29c. Licens	se number	290	. Date signed (Mont	h, Day, Year)
	î l		Monak-X	enplo	Mess	D1212	21]	Feb. 17,	2004
3	7	-	30. Name and address of person who com	//					-	
2			George Sengstack,			Dr., Wh	eaton, MI	20906		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2.6 2004	32. Registrar's		Spark	21			

			1 - State	of Maryland / Depa		lealth and N	Mental Hygier		07572
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) LEXANDER 4a. Facility Name (If not institution, give street and	D'UR	VIN	or Location of Death	2. Date of Death Month	Pay 2 Year 44c. County of Death	3. Time of Death
	Funeral Director	C1	Bon Secours Hospital 5. Social Security Number 705-03-9508 6. Sex 1 AM 2 D	7. Age (In yrs. last birthday) 93 Yrs.	Balt If Under 1 Year Months Days	imore If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yei 06/22/19	ar) 9. Birthp Coun 10 Vir	olace (State or Foreign Sginia
	ō.	stor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George	10c. City, Town or Lo					0d. Inside City Limits 1 ☐ Yes 🏖 🛣 No
	eath with the s 23a or 28 must be not	Funeral Director	10e. Street and Number 608 Salisbury Drive 11. Marital Status 12. Was D	Decedent Ever in U.S. 13.1	10f. Zip Code Was Decedent of H	20745		Citizen of What Coun	SA
9000	hours after d ural', or Item	þ	1 ☐ Never Married 2⊠ XMarried 1 ☐ Yes, 3 ☐ Widowed 4 ☐ Divorced Year of	es 2[X]No Give or Dates:	1□Yes X⊠Xo	dispanic Origin? (Span, Mexican, Puerto		Black, White,	white
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or flems 23e or 28e-f ehow event, the Medical Exeminat must be notilised at	Completed	6	ed) (Give	dent's Usual Occup kind of work done DO NOT use retired Machini	during most of work d)	Fed	eral Gove	
aryland	should be fill ind Mental H s marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) Alexander Durvin 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	Lucye	e (First, Middle, Maid Harris She al Route Number, City	epherd	Code)
Baltimore, M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event, It is Medical Examinator must be notified at ance.		Mildred Durvin / Wife 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify) Entro	20b. Place of Dispo	sition (Name of			Marylard Location - City or To	20745 wn, State
Baltir	permit. P Departme Importan any injur		21. Signatur of Funeral Service Licensee	61	2. Name and Addre	ss of Facility George F Hill Road	. Kalas Fu Oxon Hill	ıneral Hom	d 20745
	Pnysician /Medical		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one lause of immediate Cause (Final disease or condition resulting in death) Due	at caused the death. Do not enton each line. Lo (or as a consequence of):			or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of):	Levet		eliorascu	la-Dis.	
P.O. Box 68	w requires that the death certificat been signed by the attending phy should be detached for use as th	Physiclan/Medl	in the past 12 months?		Ectopic pregnancy Other (specify)	/		23d. Date of delive Month	ory Day Year
Ś	equires that sen signed b outd be deta	ted by Pł	Part II. Other significant conditions contributing to	N .		ren in Part I.	23e. Did tobacc	o use contribute to th	~
Division of Vital Record	an: The law i ificate has b or, page 2 sh	e Completed by	Renal FAI 25. Was case referred to medical	EART FAIL	URE	26 Place of Death	24a. Was an autopsy performed: 1 Yes 2 1	prior to con	psy findings available appletion of cause of
of Vi	Physicia this cert al direct	To B		Inpatient 2 ER/Outpatien		er: 4 🗆 Nursing Ho	me 5 Residence		')
ion	uttending I death. ctor: After y the funer	ation	1 Natural 5 ☐ Pending (N 2 ☐ Accident investigation	ate of Injury 28b. Time of Injury Injury	Wor	y at k? Yes 2 □ No	28d. Describe how in	lury occurred	
Divis	To the Hospital or Attending Physicien: The lawithin 24 buous after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Certification:	4 Homicide	ace of Injury - At home, farm, strulding, etc. (Specify)			28f. Location (Street City or Town, Sta	ate)	
	he Hospital n 24 hours a he Funeral I bletely filled	edical	(Check only 2 Madical Examinar: On th	the best of my knowledge, death e basis of examination and/or invanner stated.	n occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	and due to the cause red at the time, date a	(s) and manner as st. and place, and due to	ated. the cause(s)
)	To the within 2 To the complete	M	29b. Signature and title of certifier 3 4 tomillen 1	10, Physicia	70 -0	08291		Date signed (Month, I	2 0
-	(3)		30. Name and address of person who completed of FA HAMILTON, MD.	ause of death (Item 23a) (Type, 2006 W. Ba	Print) Himore S	t. Balt	moro, Mo	1,21223	3
¥	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 0 2004	2. Registrar's Signature	les				

## As Facility Name of and institution, give sized and number 15301 Pop Dar Hill Road Scote Security Number 15301 Pop Dar Hill Road Scote		ian	1- For 2-20-04 State Registrar Amend # 5. Per 1. Decedent's Name (First, Middle, Last Sylvia I	ram. PGC cr	Department of Health and Certificate of Death	2. Date of Death	No. 2004 0757 3. Time of Death 15, 2004 1:15 A
The state of the s			4a. Facility Name (If not institution, give	street and number)		th	4c. County of Death
Securitary The Price of Disposition Pauline Franks Date 2009 Tundra Ct., Annapolis, Maryland 21401	Director		577-12-0163 10		Months Days Hours Min	. (Month, Day, Yea	
23a Fayl: Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate proposed and propo	should ind Men marke umatic	Be Completed by	10a. State 10b. County Maryland Prince G 10e. Street and Number 15301 Poplar Hill 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest graded) Elementary/Secondary (0·12) 12 17. Father's Name (First, Middle, Last) Thomas Sydney But 19a. Informant's Name/Relationship (7)	Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates: 1 College (1-4or 5+) 11. Yes 2 Yes Yes	10f. Zip Code 20607 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 1 Yes 2 No Specify: 5a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired) Homemaker 18. Mother's Na Sylvia 9b. Mailing Address (Street and Number or F	Specify Yes or No- rito Rican, etc.) 16b. At Arme (First, Middle, Maidle Price Bural Route Number, City	1 □ Yes 2 □ No Citizen of What Country? ngland 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry - Home en Sumame) y or Town, State, Zip Code)
The part of the	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other 1 000c.		20a. Method of Disposition 1	Removal from State 20b. Place ceme Mary 1	of Disposition (Name of tery, crematory or other place) and Veterans Cem. 02/2 22. Name and Addrass of Facility Ge.	Date 20c. Che corge P. Kal	Location - City or Town, State eltenham, Maryland .as Funeral Home,P. .l, Maryland 20745
1	Medical Examiner Asician and parial-transit	cal	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	F 7RE LUNG (e of):		
1	the death ce the attendi	ysiclan/I	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\bar{\text{N}} \text{No} \)	1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death			•
25. Was case referred to medical examiner? Top To	quires that en signed by	þ	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cause given in Part I.		
Security						autopsy performed?	death?
	cian	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b	Outpatient 3 DOA Othar: 4 Nursing I Time of Injury Work?	Home 5€ Residence	
	w :5	O	dataminad	building, etc. (Specify)	farm, street, factory, office	City or Town, Sta	ite)
	w 5	I Certifi	202 Corifice 1 Cortifuing Phys	nining. To the heat of my knowled			s) and manner as stated
The state of the s	W 15	edical	(Check only 2 Medical Exami	ner: On the basis of examination a	and/or investigation, in my opinion, death occ	urred at the time, date a	nd place, and due to the cause(s)

			1- For Amend Item 5 pe	r \$12,5829 M3/Y17044 Depa	artment of Health and Nartificate of Death	lental Hygie		07571
Ŧ.	19	ű,	1. Decedent's Name (First, Middle, Las)		2. Date of Death	3.	Time of Death
	Physici Medi		Janet Kane Day			February	15, 2004	3:22 p M
ign.	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	Ī	4c. County of Death	
			Washington Adven	tist Hospital	Takoma Park	ļ	Montgomery	
沙葵	Funeral Director		370-03-7404	x 7. Age (In yrs. last birthday) □ M 2뮻 F 79 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You Jan. 20,	9. Birthplace Country) Pennsy	(State or Foreign Vania
	72 hours after death with the Maryland natural; or items 23e or 28e-f show dical Exar in a read be retified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince (10e. Street and Number	George's College F		10g.		nside City Limits
	h with		9714 48th Place		20740	U	.S.A.	
920	ai', or items?	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	1 Yes 2 No	Was Decedent of Hispanic Origin? (Spr f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2⊠ No Specify:		14. Race - American In Black, White, etc. Specify: White	dian,
21215-0036	within 72 ho ene. than *natur to Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ng	c. Kind of Business/Industry	/
Maryland 2	uld be filed within lental Hygiene. rked other than ilc event, It a Mu	To Be Co	17. Father's Name (First, Middle, Last) George Edward Kane			(First, Middle, Mai		
re, Mary	riit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan sertment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural; or items 23s or 28s-1 show injury or other traumatic event, it is Medical Extratible from the rectified.		19a. Informant's Name/Relationship (T) Carol A. Grey - De 20a. Method of Disposition	aughter 9008	Adelphi Road., Ad sition (Name of natory or other place)	elphi, Ma		3
Baltimore,	permit. Pages 1 am Department of Heali Important: If item 2 any njury or other ance.		1 ☑ Burial 2 ☐ Cremation 3 ☑ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	St. Ignat	ius Cemetery 2/20/ Name and Address of Facility Ga 39 Baltimore Ave.	'2004 01 sch's Fun	rrtanna, Penr eral Home, P	nsylvania .A.
	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ications that caused the death. Do not entere cause on each line. a. SMALL BOWE Due to (or as a consequence of): Due to (or as a consequence of):	er the mode of dying, such as cardiac of L ISCHEMIA	THROGO	Apprinter Ons	roximate val Between et and Death day S
.O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Ves} \) 2 \(\text{Ves} \)	Due to (or as a consequence of): 3 3c. If yes, outcome of pregnancy 1 \(\triangle \tr	TIC CARDIONASC Ectopic pregnancy Other (specify)	ULAR D	23d. Date of delivery Month Day	YEAYS
۵.	uires that the signed by to d be detach	by	0 1 · + ·	atributing to death but not resulting in the un	4 >		co use contribute to the cau	
Records,	25 0	Completed	Hypertension	; Obesity	- Disease	24a. Was an autopsy performed	24b. Were autopsy fir prior to complete death?	idings available on of cause of
Vital	ian: rtifica ctor.	Bec	25. Was case referred to medical		26. Place of Death		10 10 201	
	nysic nis ce I direc	To E	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatient	04		6 ☐Other (Specify)	
Division of	Attending Physician: The Indeath. ector: After this certificate haby the funeral director, page		27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		8d. Describe how in		
DIX	oital or Attendurs after death oral Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		City or Town, St	,	e Number,
	To the Hospital or At within 24 hours after с To the Funeral Direc completely filled in by	Medical	one)	ician: To the best of my knowledge, death ner: On the basis of examination and/or invi- and manner stated.	estigation, in my opinion, death occurre	d at the time, date a	and place, and due to the ca	
	1 1 2 B	_	29b. Signature and title of certifier	AMD.	29c. License number D 22549 Print) Riverdale Me	29d. (Date signed (Month, Day, Y	2004
	(13)		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, F	re Riverdale M.	D 2073	7	
	Star Registra		FED 1 8 2004	32. Registrar's Signature				

		ŀ	1 - For State Registrar	State of Ma	aryland	•			lealth a Death	nd M	ental H	ygiene Reg. No	200	L	075	575
			Decedent's Neme (First, Middle, Las	1)							2. Date of D	eath Da	y Yea		3. Time of D	Death
	Physici /Medio		CURTIS M. D	UDLEY							Feb.		2004	ar	6 ¹	А м
*	Examin		4e. Fecility Name (If not institution, give	street and number)			4b. City	, Town, or	Location of			40	. County of D	eath		
			Millennium Nsg.						shing				P.G.			
	Funeral		5. Social Security Number 6. Se	X 7. Age		ast birthday)	Months		If Under 2 Hours	Min.		Day, Year)		Birthpla Count	ace (State or a	Foreign
40	Director		719-14-0901 Usual Residence of Decedent		8	37 Yrs.			l		Dec.1	8,	1916	VA		
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside City	Limits
	Mary In	ţ	Md. P.G.		1	Fort	Mach	ina	ton						1x Yes 2	2 🗌 No
	r 288	Director	10e. Street and Number			COLU	10f. Zi	p Code	rom			10g. Cit	izen of What	Count	ry?	
	72 hours after death with the Maryland natural', or flame 23a or 28a-f ehow lical Examinet must be notified at	ai D	12021 Livingst	on Road			2	2074	4			Uni	ited S	Sta	tes	
	dea	Funerai	11. Marital Status	12. Was Decedent I		S. 13. V	Vas Dece	dent of Hi	ispanic Orig	in? (Spe	cify Yes or N Rican, etc.)	lo-	14. Race - A Black, W			
9	or its	F.	1 Never Married 2 Married	1 X Yes 2 □ N	74	2- 1	Yes		Specify:	, , 40,10 ,	nour, oto.,		Specify:	, inte	16.	
8	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates:	194	5						1	E	31a		
ry	hin 72 ho s. an "natu Modical	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	kind of w	ial Occupa ork done d ise retired	during most	of workin	ng	16b. K	ind of Busine	ss/Indi	ustry	
21215-0036	E E B Wi	E D	Elementary/Secondary (0-12) Unknown	College (1-4or 5	+)				, o Pool	1			Gover	• 12 ×4	ont	
0 0	Hygi ther ant, I		17. Father's Name (First, Middle, Last)			CHIEL	OI	necre			(First, Middl			111()	enc	
<u>a</u>		To Be	John Dudley						Dosl	hia	Di-	vers				
Maryland	S D E E	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Addres	s (Street a	and Number	r or Rurai	Route Num	ber. City o	r Town, State	в, <i>Zip</i> (Code)	
	1 and 2 Health a Iem 27 Ie		Evelyn D. Hawk	ins/daud	hte	r Fo	200	Vash	th of	f Ta	e Dr	3894	4			
ore,	of He		20a. Method of Disposition	D	20b. PI	ace of Dispos	sition (Na	me of		D	ate	20c. L	ocation - City	or Tov	vn, Stete	
Ē	Pages nent of ant: If It ary or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Ft.	Line	coln	Cen	n. 2	/25	/04	Bre	entwo	od,	Md.	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	900	,) 22	. Name a	nd Addres	s ol Facility	Hode	ges a		dward			
<u> </u>	82559		Musice 2	auru	de								land,	Md	.2074	6
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or competitions, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each lin a	1/10	Carclin	I in	fair 1	f(cn)	cardiac or	r respiratory	arrest,			Approximate Interval Betwe Onset and De	een eath
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	a consequ	ience ol):	2 1	me	K ₁ 1				•			
	ate be executed by sician and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience of):	210	us si	" /) ·					+		
8760,	be e sician buriz	ai				Cer	chro	Va	cule	- a	ccide	I i	villa			
687	ficate physics the	edicai		O					1/1							
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic p Other (s	pregnancy pecify)					23d. Date of o Month		y Day Ye	ear .
S, D	that ned b	by Pł	Part II. Other significant conditions of	entributing to death be	ut not resu	alting in the ur	nderlying	cause give	en in Part I.	ì	23e. Did	tobacco	use contribute	to the	cause of dea	ath?
rds	quires n sign ald be			left	Ab	are Th	0 19	ee_	Aus	Per 1-	1	Yes 2	□No 3□	Proba	biy 4 XUn	known
of Vital Record	sw requir	Completed		D.e	11-0	tien					24a. Wa		24b. Were	autop	sy findings av	ailable
Ä	The lav	шо									per	opsy formed? *******No	death	?	pletion of cau 2□ No	JSØ OT
ita		0	25. Was case referred to medical						26. Place	of Death	(Check only					
>	ys dills	To B	examiner? 1 🗌 Yes 2 📮 No	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	ER/Outpatien	t 3□ D	OA Othe	er: 4 = Nur	sing Hom	ne 5□Res	sidence	6 □Other (S	pecify)		
	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury		28c. Injury Work	at	2	8d. Describe	how inju	y occurred			
Sio	Attending or death. ctor: After by the fune.	atic	2 Accident investigation				М		Yes 2□N	10						
Division	P Sign	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	iry - At hoi c. (Specify	me, farm, stre	et, factor	ry, office		2		(Street an own, State		Rurai	Route Numbe	9 <i>r</i> ,
	To the Hospital of within 24 hours at To the Funaral D completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	rsician: To the best of iner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred estigation	dat the tim	ne, date and pinion, death	i place, a h occurre	and due to the	e cause(s) o, date and	and manner d place, and d	as sta	ted. he cause(s)	
	To the Vithin 2 To the comple	ž	29b. Signature and title of certifier				-	c. License		-		29d. Da	te signed (Mo	onth, D	ay, Year)	
			K. ()	anne G		ž.	C	D25	1401	0		2-	20-6	4		
2	14/1	VO	30. Name and address of person who	completed cause of de	eath (Item	23а) (Туре,	Print)			-				1		
			Dr. Khosrow Da				Bran	nch	Ave.	, C1	into	n,Md	.Suit	e#	409,2	073
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registra	ar's Signat	ture										

		1 - State Unpend Item#23a,27,Per Me,6829,3/	19/ Xig	tificate of	Death	-		
Physicia /Medic		1. Decedent's Name (First, Middle, Last) James P.L.	Domir	10		2. Date of Dea Month MARCH	Day	3. Time of Death 12:55 P
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	
·		2549 CHEVAL DR	and the limite and a second	DAVII tf Under 1 Year	DSONVILLE If Under 24 Hrs.			ARUNDEL CO
Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. la</i> 219-80-1460 1 № 2□ F 43	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day APr	2 ^{Year} 960	9. Birthplace (Stete or Forei Country) Maryland
and	}	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limi
28a-f ehow	ō		David	lsonvill	.e			1 ☐ Yes 2 🖾 N
28a notifi	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	nat Country?
23a or		2549 Cheval Drive			21035		USA	
- 1	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		- American Indian, White, etc. White
ene. than "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+)	(Give life. L		ation during most of work f)	ing		ness/Industry eration ce Co.
other th	Co	17. Father's Name (First, Middle, Last)	мал	lager	18 Mother's Name	e /First Middle	Maiden Sumame	
1 de de 1	Be c	Robert Domi	n o			a Mae	_	
Health and Menta	2	19a. Informant's Name/Relationship (Type, Print)		g Address (Street	and Number or Run			tate, Zip Code)
27 is r trau		Anna Mae Domino - Mother	2549	Cheva1	Dr., D	avidso	nville,	Md. 21035
		1 Burial 2 Cremation 3 Removat from State	metery Crem	sition (Neme of natory or other place)	e) Cem.	10-04	20c. Location - C	ity or Town, State , PA 16630
Department of Important: If eny injury or once.		21. Signature of Funeral Service Licensee		Name and Address	ss of Facility B		uneral Bowie,	
		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory an	rest,	Approximate Intervat Between
nysician		tmmediate Cause (Finat disease or condition Atherosclerotic	Cardio	ovascular D	isease			Onset and Death
Medical xaminer		resulting in death) Due to (or as a consequence)	ence of):					
ammer	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequent to the conditions).	nno of):					
Jsit	nlne	rt any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events c.	site of).					
	edical Examin	that initiated events resulting in death) Last	ence of):					
- 07		AF FEMALE.						
ed by the attending p detached for use as	Physician/M	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnan 1 Live birth 2 Feal of 4 Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)			23d. Date Month	
gne be d	þ	Part It. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause give	en in Part I.		/	ute to the cause of death?
ate has been signed by th page 2 should be detache	Completed					24a. Was a autop perfor	an 24b. We sy prid med? de:	ere autopsy findings available to completion of cause of att?
= 5	0	25. Was case referred to medical			26. Place of Deatl			Yes 2□No
is cert direct	To B	examiner? 1 ☑ Yes 2 ☐ No Hospitat: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Othe				(Specify) SCENE
death. stor: After thi	atlon: 1	27. Manner of Death 1 S Naturat 5 Pending 2 Accident investigation 28a. Date of thjury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🔲			ow injury occurred	D 0 10 10
rs after death. rel Director: After	Certification:	3 Suicide 6 Could not be determined 28e. Place of thjury - At hombuilding, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
within 24 hours a To the Funerel I completely filled	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tin restigation, in my of	ne, date and place, pinion, death occurr	and due to the o	cause(s) and mann date and place, and	ner as stated. d due to the cause(s)
within To th comp	Me	29b. Signature and title of certifier		29c. License		2	29d. Date signed (
(h)		30. Name and address of person who completed cause of death (Item:) 23a) (Type. i		CME		MARCH 7	, 2004
3/		MARYAMON D. KOROL		111 Per	nn Street	, Baltir	more, Mai	ryland 21201
Stat Registra	_	31. Date filed (Month, Day, Year) MAR 0 8. 2004 32. Registrar's Signatu	Appen					

DHMH 17 Rev 1/2001

			1 - State of Maryland	Certificate of	of Health and N of Death	lental Hygid Red	ene 200	4 07577
	Physici /Medic		Decedent's Name (First, Middle, Last) Charles Edward Essich			2. Date of Death Month February	Day Year 7 22, 2004	3. Time of Death 1 1357 M
)	Examir		4a. Facility Name (If not institution, give street and number) Carroll Hospital Center		on, or Location of Death stminster		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 70		ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day,) Dec 9,]		thplace (State or Foreign ountry) Cyland
death with the Maryland	"natural", or items 23a or 28a-f show solical Examinat must be notified at	Director		own or Location	Finksburg		g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
ath with	s 23a or	rai Di	2525 Baltimore Blvd #21		Carroll		USA	
5-0036 72 hours after de	ral', or item Examinar i	d by Funeral	3 ¼ Widowed 4 ☐ Divorced Year or Dates: 1959	13. Was Decedent If Yes, specify (1 □ Yes 2反	of Hispanic Origin? (Spi Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
within	tal Hygiene. d other then "natu event, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)	6a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re Truck Di	one during most of work atired)	ing 16	Sb. Kind of Business. Truck I	
aryland 2 should be filed	# D •	To Be C	17. Father's Name (First, Middle, Last) Albert Henry Essich		Mary E	e (First, Middle, Ma lizabeth	Hancock	
B, Mal	t of Health and Mer If Itam 27 Is marke or other traumatic		Linda Beverly, step daughter	A SOCIAL SECTION ASSESSMENT ASSES	le Road, Ma	nchester,	MD 21102	2
Dailtimore	Department of Health i Important: if Itam 27 I eny injury or other tra once.		1 CE DUNAL 2 CHANNELION 3 CHANNOVALINON STATE	o of Disposition (Name o etery, crematory or other Abraham's (c. Location - City or Hampstea	
Dail	Departi Import eny inj		21. Signature Fineral Service Licensee M60723	22. Name and Ac 934 Sou	ddress of Facility E th Main St,		eral Home ad, MD 21(074
1	ysician Medical caminer		23a. Part1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque to the condition of the condition	fractor	dying, such as cardiac of	er respiratory arrest	HE	Approximate Interval Between Onset and Death
ficate be executed	physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underthying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the conseque					- Cluz
UNISION OF VITAIN TRECORDS, F.O. BOX 00/00, for the Hospital or Attanding Physician. The law requires that the death certificate be executed	been signed by the attending p should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death				23d. Date of del Month	ivery Day Year
w requires that	en signed b ould be deta	ted by PI	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause	given in Part I.		co use contribute to	
ion: The lawr	within 24 hours after death. To the Funeral Director: After this certilicate has be completely filled in by the funeral director, page 2 sh	Completed	1	/		24a. Was an autopsy performed	d? prior to death?	topsy findings available completion of cause of
Physician	this certif al directo	To Be		Outpatient 3 DOA			e 6 ⊡Other (Spec	eify)
STOIL O	eath. tor: After the funera	Certification:	1 Matural 5 Pending (Month, Day Year) 2 Accident investigation	M 1	Work? I □ Yes 2 □ No	8d. Describe how		
ital or At	irs after d ral Direct led in by	Certifi	4 Homicide determined 286. Place of Injury - At nome, building, etc. (Specify)			City or Town, S		
the Hosp	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled to the basis of examination and manner stated.	ge, death occurred at the and/or investigation, in m	e time, date and place, a ny opinion, death occurre	nd due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
·		2	29b. Signature and title of certifier Diplomatic and title of certifier		D Z301	29d.	Date signed (Mohth	Z OLL
lo	TUA		30. Name and address of person who completed cause of death (Item 23a 2 7	Washing	Hon Her	glb M	ed Ctr.	Wetminle
	Sta Registr	ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 4 2004	the Search	,			1 ria (1157)
HMHU	17 Rev 1/20	001	OF	RIGINAL				

Director

Funeral

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Completed

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attending physician and for use as the burial-transit The law requires that the death certificate be executed been signed by the a should be detached t this certificate has director After

Physician/Medical

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Completed

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Certification:

Division of Vital Records, P.O. Box 68760. Hospital or Attanding Physician: 44 hours after death. Funarel Diractor: After this certifica the funeral filled in by within 24 hours a To tha Funarel C completely filled

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year BETTY WILLIAMS EDNIE Feb 19 2004 2:15 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Easton Talbot The Pines Genesis ElderCare If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) JAN 10 1921 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Hours Days 1□M 2XF WISCONSIN 83 388-14-6193 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1**Y**Yes 2 □ No EASTON MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 USA 610 DUTCHMANS LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status | ☐ Yes 2 ☑ No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏋 No Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) BESSIE ENTERS ROBERT E. WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 PEACH AVE. HERSHEY, PA 17033 DOUGLAS L. EDNIE/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 2-20-2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERA 200 S. HARRISON ST EASTON, MD 21601 HELFENBEIN & NEWNAM FUNERAL HOME PA JOHN K. MERCER 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bon Due to (or as a consequence of): Sequentially list conditions, I my leading Limitage cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Trursing Home 5 Residence 6 Other (Specify) 1 🗋 Inpatient 1 Tes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar MD

. Registrar's Signature

DANCHEZ

		1 - For State Registrar	State of Marylan	d / Depa	artment of Health and rtificate of Death	Mental Hygie	ne No. 2004 07579
Physic /Medi		Decedent's Name (First, Middle, Last, Karen Lavonne Est	leman			2. Date of Death Month	Day Year 7 45 AM
Exami	ner	4a. Fecility Name (If not institution, give			4b. City, Town, or Location of Dea	th	4c. County of Death
		11918 Air View I		lact highday)	Hagerstown If Under 1 Year If Under 24 Hrs	8. Date of Birth	Washington County 9. Birthplace (State or Foreign
Funeral Director		0.000	T. XPW-	16 Yrs.	Months Days Hours Min	(Month, Day, Ye	1957 Maryland
yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation		10d. Inside City Limits
Mar	ţō	Maryland Washing	gton	Hagers	stown		1 Tyes Anno
h the	Directo	10e. Street and Number			10f. Zip Code	10g.	. Citizen of What Country?
death with the Maryland ms 23a or 28a-f ehow rithet be inclifted at	ai	11918 Air View Ro	oad .		21742		U.S.A.
p 2 3	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puei 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland ZIZIS-UUSO d 2 should be filed within 72 hours after th and Mental Hygiene. ?? Ie marked other then "natural", or ite fraumatic event, the Mexical Exercities	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	nrking 16b	b. Kind of Business/Industry
and Z abe filed intal Hygid ed other	Be	17. Father's Name (First, Middle, Last)				me (First, Middle, Mai	den Sumame)
Maryla d 2 should th and Men 7 le marke	7	John M. Fshleman 19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Street and Number or R	G. Martin ural Route Number, C.	ity or Town, State, Zip Code)
Mar od 2 s lith ar ith ar trau	-	John M. Eshleman/					n, Maryland 21742
s 1 and f Healt itam 2 other	10.0	20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place)		c. Location - City or Town, State
00		1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State Par	adise	Mennonite Cem. F	eb. 21, 2004	4 Hagerstown, Maryla
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe		21. Signature of Funeral Service Licens		22	2. Name and Address of Facility	uglas A. Fi	iery Funeral Home stown, Maryland 21742
Physician (Be pe executed Asician and Parish transit April 1. Transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	refardation		43 Years
ath certificate	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregns 1	I death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
quires that the de	b	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
	Completed	<i>O</i>				24a. Was an autopsy performed	
VICIAN: The certificate rector, pag	Be	25. Was case referred to medical examiner?	In an Andrew			ath (Check only one)	
Ol VICAL Physician: rthis certifica	2	1 Yes 2 No		ER/Outpatier			e 6 Other (Specify)
DIVISION OF SIGNATION OF A SIGNATURE OF A SIGNATURE OF SI		27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i	njury occurred
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	y)		City or Town, S	
Lo the Hospitel within 24 hours a To the Funeral	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat ition and/or in	h occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier	1		29c. License number	- Contraction	Date signed (Month, Day, Year)
		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type.	Print) M.	7-21/1	B-18; 2004 SUITE 200
	ate	31. Date filed (Month, Day, Year) FER 2.4.2	32. Registrar's Signa	ature (gentrown MI	11/40.	Solle Coc
Regist	rar	10242	UU4	18. 1	Tan M. I		

				State of Maryla				-	ene	
			1 = For State Registrar	J		rtificate of			g. No. 200	4 07580
	81		1. Decedent's Name (First, Middle, Las	i)				2. Date of Death Month	Day Yeer	3. Time of Death
	Physici /Medic Examin	al	Gregory Jose 4a. Facility Name (If not institution, give		1	4b. City, Town, o	r Location of Deat	February		11:15 A ^M
			705 Woodburn Ro	ad		Rockvi	11e		Montgo	mery
	Funeral		5. Social Security Number 6. Se	XM 2DE	s. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year) 9. Bi	rthplece (State or Foreign ountry)
	Director		Usual Residence of Decedent	/ 8	Yrs.			March 1/	,1925 Was	hington, DC
	Maryla B-f shov	tor	10a. State 10b. County Maryland Montgom	_	Rockvil.					10d. Inside City Limits 1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What C	,
	s 23s		705 Woodburn Ro		11.6	20850			Jnited Sta	
326	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel; or items 23a or 28a-f show aumatic event, the Madical Examiner rules to modified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 □ No 10 If Yes, Give Year or Dates: 10	1/2	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		pecry res or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	"nature	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	edent's Usual Occup a kind of work done DO NOT use retired	during most of wor	rking	6b. Kind of Business	s/Industry
7	withir ene. then	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		ervisor	1)		Telephon	.e
פַ	e filed of her ont,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, M		
/lar	should by and Menta marked umatic sy	To E	Gregory A. Eckho	1m			Eliza	beth McCa	rthy	
Mar	and 2 sho ealth and I n 27 is m		19a. Informant's Name/Relationship (7 Helen Kirk / Fr		1	S. Leisu			City or Town, State, A Silver	Zip Code) 20906 Spring, MD
e e	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic av once.		20a. Method of Disposition 1 🖔 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify	Hellioval Irolli State		osition (Name of matory or other plac Memorial	Danis ret	o. 25,	ockville,	
Baltii	permit. F Departme Importer any injur		21. Signature of Fur eral Service Licens		2	2. Name and Addre	ss of Facility D	eVol Fune	ral Home	•
	2	1 - 24	23a. Part1. Enter the disease, or comp	lications that caused the de		O E. Deer			rsburg, M	D 20877 Approximate
i	Physician /Medical		shock, or beart failule. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line. a. <u>Myocardial</u>	Infaro					Onset and Death 6 Minutes
7	Examiner			Due to (or as a conse	equence of):					
Q .	nted nsit	Examiner	Sequentially list conditions, if any, Isaamy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a sons	equance of):					
,097	e be executed rsicien and e burial-transit	cal Exa	resulting in death) Last	Due to (or as a conse	equence of):					
				u.						
O. Box	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year
o,	w requires that the base of the part of th	by Phy	Part II. Other significant conditions co	intributing to death but not re	esulting in the u	underlying cause give	en in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
brd	equire sen si	ted						1 🗆 Yes	2 □ No 3 □ P	robably 4 X Unknown
		Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of s
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		th (Check only one)	
ō	Phys rthis raldir	70	1 X Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie		4 🗆 (4u) 3ii lý (1	ome 5 X Resider 28d. Describe how	ice 6 Other (Spe	ecify)
Division of	Afte	catlon	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Worl	k? Yes 2 □ No	Ebd. Describe nov	Tingary occurred	
DIVI	를 를 들	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Spec				City or Town,	·	
	Fu 4 Ho	Medical	29a. Certifier 1 X Certifying Phy (Check only 2 Medical Exemone)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	th occurred at the timestigation, in my of	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed (Mon	th. Day, Year)
١	3		(lunos fa	of les		D397	93	F	ebruary 2	3, 2004
,	1		30. Name and address of person who o				in Drive	#328 01	nev Maru	land 20838
	- 640	10	Christopher J. N 31. Date filed (Month, Day, Year)	lays, M.D. I		· D		17320 01	ney, raly	Tallu 20030
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			1 - For State Registrar	State of	Marylar		artmen rtificat				ental Hy	gien Reg. N		001	+ 07	58
21	D 1		1. Decedent's Name (First, Middle, Las	•							2. Date of De		ay	Year	3. Time of	Death
	Physici /Medi]	Dorothy (Gill E	Edmonds					Februa	ry 2	24, 2	004	8:10	ΑM
	Examir	ner	4a. Fecility Name (If not institution, give		er)				Location of	of Death		4	c. County	of Death		
			7511 Arlington Re		Ann /Im um	lant hinth days		hesd	la If Under	24 Hrs	8. Date of Bi		Monte		y place (State o	- Famina
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 1	ex □M 2∏ F / .	93	last birthday) Yrs.	Months	Days	Hours	Min.	June 2	ay, Yea	910	Coui	ntry) Lingtor	
			Usual Residence of Decedent						i		June 2-	т, 1	710	wasi	IIIIgcol	.1
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside Ci	•
	a-fel	io	Maryland Montgo	nery	į	Bethes	da								1 🗆 Yes	2/No
	or 28	Olre	10e. Street and Number				10f. Zip	Code				10g. C	itizen of V	Vhat Cour	ntry?	
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	er de	une	11. Marital Status	12. Was Decede Armed Force	s?	J.S. 13.	Was Deced f Yes, spec	dent of Hi cify Cuba	ispanic Ori n, Mexican	gin? (Spe 1, Puerto f	cify Yes or No Rican, etc.)	0-		e - Americ k, White,	ean Indian, etc.	
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	ie. ΣΊνο		1 🗌 Yes	2 ∏ No	Specity:				Specify	. Whi	te	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jisal Examiner must be rodified at	ed	15. Decedent's Ed			16a. Dece						16b.	Kind of Bu			
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pu	at Hy f oth	Be (17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	, Maide	n Sumam	10)		
yla	Ment Ment arked	2	Forrest I. Gill						Eth	nel G	atward					
Maryland	2 sho		19a. Informant's Name/Relationship (7				-				Route Numb					
2	and lealth m 27 her tu		Amy E. Christald	i /Daugh		4031 Place of Dispo			reet,		vy Cha					
Ore	Toring V		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from Sta	ate (cemetery, crer	natory or o	ther plac	11.	ebrua	ary 25		Location -	•		
Baltimore,	t. Pa		4 □Donation 5 □ Other (Specify		Mon	tgomery (200)4	Bet	hesd	a, Ma	arylan	d
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury of other traumatic avent, the Medical Evaturer must be notified at once.		21. Signature of funeral Service Licen	200	м01	Ro	bert A	. Pum	s of Facilit phrey n Aven	Funera	al Home/ ethesda,	Beth Mar	esda-(yland	Chevy 20814	Chase, -3501	Inc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cau one cause on eac	sed the deal h line.	th. Do not ent	er the mod	le of dyin	g, such as	cardiac o	r respiratory a	arrest,			Approximate Interval Bets Onset and D	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Park:	inson'	s Dise	ase								7 Year	S
9	/Medical Examiner		resulting in death)	Due to (or	as a consec	quence of):										
в	ķ	100	Sequentially list conditions,	b. — Due to (or	as a consec	nence of):										
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Ć,	certificate be executed iding physicien and ise as the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or	as a consec	quence of):					<u> </u>					
8760,	ate be hysicie the bur	dical	(d												
9	tificat 19 ph) as th	ed														
Box	leath certifica attending ph I for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			Ectopic pr	ennancy						e of delive	-	
	0 0 0	Sicia	in the past 12 months? 1 □ Yes 2 🖾 No	4☐Pregnan 9☐Unknow	t at time of c		Other (sp						Mor	ntn	Day Y	'ear
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	w requires that been signed to should be det		Part II. Other significant conditions of Dementia	onthouting to deal	n but not res	sutting in the u	naeriying c	ause give	en in Part I.			Yes 2			abiy 4 □U	
orc	requi	Completed by	Dementia								-					
ec	og ∨ ∨ ∨	du		·				<u> </u>			24a. Was	psy	24b. V	Vere auto	psy findings a mpletion of ca	available ause of
A F	That are pag	ပ္ပိ									1 ☐ Yes	ormed? 2X N	0 1	Yes	2 No	
Vital Records,	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_		Othe	26.		(Check only					
ō	₩	-T	1 ☐ Yes 2 X No 27. Manner of Death	1 🗀 Inp		ER/Outpatier		JA	4 🗆 Nu		ne 5 🔀 Resi				v)	
on	ding Ph h. After th funeral	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month,	Day Year)	Injury	м	28c. Injury Work	<br Yes 2 □ I				.,			
Division	Attending r death. ector: After oy the fune	Certification:	3 Suicide 6 Could not be	28e. Place of	Injury - At h	ome, farm, str	eet, factory	y, office		2	8f. Location (er or Rura	I Route Num.	ber,
Ö	after after Dire	erti	4 Homicide	building	etc. (Speci	fy)					City or To	wn, Sta	te)			
	To the Hospital or Attendi within 24 hours after death. "To the Funeral Director: A completely filled in by the fu	edicai C	29a. Certifier (Check only 2 Medicel Exert	niner: On the basi	s of examina	owledge, death ation and/or in	n occurred vestigation	at the tim	ie, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) and ma nd place, a	nner as st	ated. the cause(s)
	thin 2 the the mple	Med	one) 29b. Signature and title of certifier	and manne	31a18U.		290	c. License	number			29d. D	ate signed	(Month.	Day, Year)	
	¥ ¥ × 8) IV.	1.												
	25		30. Name and address of person who	completed cause	of death /Ita	m 23a) /Tune	Print\	D20	36/			ŀ'ebr	uary	25,	2004	
			Joel P. Kalman,	111		xecuti		นไอง	ard.	Rocks	ville	Mar	v1an	ብ ኃ ሰ ዩ	352	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Reg	istrar's Sign		-	re the			,	. 144				

			1 - For Registrar	State of	Marylan		artmen rtificate			and M		giene Reg. No.	200) 4	07582
П	Physici	on.	1. Decedent's Name (First, Middle	, Last)							2. Date of De Month	Dav	Y	er	3. Time of Death
	/Medic		William Amba							15	Februa		24, 20		9:35P M
	Examin	ier	4a. Facility Name (If not institution	-	ber)		, ,		Location of	of Death			County of I		
	-		Manor Care-Po		. Age (In yrs. i	last birthday)	If Under		If Under		8. Date of Bir	th	nt gor	Birthple	ece (State or Foreign
	Funeral Director		281-26-3510	1ሺM 2□F	87	Yrs.	Months	Days	Hours	Min.	Oct. 2	5, Year	916	Count Mary	vland
7	2 ,		Usual Residence of Decedent		10e Cib	, Town or Lo	antion							10	d. Inside City Limits
-	ehow	>	10a. State 10b. County												1 X Yes 2 No
9	288-f	by Funeral Director	D.C		Was	shingto	0 n 10f. Zip	Code				10g. Citi:	zen of Wha	t Count	ry?
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4100	ms 2	Jera	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13.	_			gin? (Spe	cify Yes or No Rican, etc.)		14. Race -	America	n Indian,
0	or ite	F	1 Never Married 2 ☐ Marri	ied 1 X Yes 2	2□No Wor	ld	1 ☐ Yes 2		Specify:	, 1 00101	mount, oto.,		Specify:	1411110, 0	
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	other	BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle	Meiden	Surname)		
אומוום	Menta Menta Irked Itic e	To B	Irvin Eichen	green					Ett	a Am	bach				
מון	permit. Faggs 1 and 2 should be filled which 72 hours after death with the maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	1 0	19a. Informant's Name/Relations	hip (Type, Print)							l Route Numb				
ב ב	and lealth m 27 her tr		Stefan Leigh/F	riend	20h B	19084 lace of Dispo			n Dri		Germant ate		Mary cation - Cit		
	T I I		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation			emetery, crer	natory or or	ther place	, -	Febru	ary				
Dail IIIO	rtant nury		*4 □ Donation 5 □ Other (S		Cre	ntgomen emator:	ium, I	Inc.	s of Facilit	26, 2 v Rob	2004 ert A.	Beth	nesda. Ohrev	Fun	ryland eral Home/
ם ם	Depa Impo Impo		1.08	3 2 2	_ MO08	303 B	ethes	da-Cl	hevy	Chas	e, Inc.	755	7 Wis	scon	eral Home/ sin Avenue
			23a. Part1. Enter the disease, or	complications that ca	the death										Approximate Interval Between
P	hysician		shock, or heart failure. List Immediate Cause (Final		ch line. Cyngeal	Canao	. 12								Onset and Death
	/Medical		disease or condition resulting in death)	a.	or as a consequ		: L								
E	xaminer		Sequentially list conditions.	b											
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XOC S	anding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna th 2 ☐ Fetal		∃Ectopic pro	agnancu				2	3d. Date of		
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,	ignec be d	by	Part II. Other significant condition	ons contributing to dea	ath but not rest	aiting in the u	nderlying ca	ause give	min Paπi.				_		cause of death?
cords,	been si	Completed											T		
בי ביינו ביינו	hast Je 2 s	ig m									24a. Was autor perio			to com	sy findings available pletion of cause of
	ning ringstriet. The h. After this certificate he funeral director, page		25. Was case referred to medical				_		00 84	. ()	1 ☐ Yes	2X No	10	Yes 2	!□ No
VILGI	s certi	o Be	examiner? 1 Yes 2 No	Hospital:	patient 2	ER/Outpatien	nt 3□ DO	A Othe			<i>(Check only c</i> ne 5□ Resi		Other (Specify)	
5	erthis eraldi	-	27. Manner of Death	28a. Date of		28b. Time of		8c. Injury Work	at		8d. Describe			op , ,	
SION	death. tor: After the funer	atlo	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	ation	, Day You,	i i july	М		/es 2 □ I	No					
	rer de iracto	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Place	of Injury - At ho g, etc. (Specify	ome, farm, str	eet, factory	, office		2	8f. Location (3 City or Tox			r Rural	Route Number,
ָב בַּ	urs af		<u> </u>												
UIVISION OF VICAL DECOURS, F.O. BOX 60/00,	vitin 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical		g Physician: To the t Examiner: On the bas and manner	sis of examinat										
4	o the	Me	29b. Signature and title of certifie				29c	. License	number			29d. Date	e signed (N	fonth, D	ey, Year)
1	- 5 - 6		1 Alkarat	2 por au	1	M.D.	I	276	60			Febr	uary	25.	2004
01			30. Name and address of person	wto completed cause	of death (Item	23a) (Type,	Print)								
			Alpana Goswami		119 Ro					Roc	kville	, Mai	rylane	d 2	0852
	Sta		31. Date filed (Month, Day, Year) FEB 2 7		gistrar's Signa	ture &	100	ukr	1						
	Registr	ar	FED 21	LUUT			//								

N			1 - State Registrar	State of Mai	•	artment of I <i>rtificate of</i>			giene Reg. No. 🤈	nni	0750
4	Physici		1. Decedent's Name (First, Middle, Last Allen Temple Ell					2. Date of Dea Month Februar		ооц 0ď 4 ″	3. Ume of Dan
100	/Medic Examin		4a. Facility Name (If not institution, give Prince George's I		enter	4b. City, Town, Chever	or Location of Dea	th		ty of Death	orge's
	Funeral Director		Social Security Number 6. Se	_	(In yrs. last birthday) 85 Yrs.		If Under 24 Hr		h v. Year)	9. Birthpl Count	ace (State or Foreign try) , Virginia
	ט)r	Usual Residence of Decedent 10a. State 10b. County MD Prince 0		10c. City, Town or Lo			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Od. Inside City Limits 1 XYes 2 No
	with the N a or 28a-f	Directo	10e. Street and Number 5312 Tilden Roa	a		10f. Zip Code	710		10g. Citizen of	What Coun	try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 is marked other than "natural", or items 23e or 28e-f ehow enty injury or other treumatic event, the Medical Exatta at main Lie mullish at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Myes 2 No If Yes, Give Year or Dates:]	1943-	Was Decedent of	Hispanic Origin? (pan, Mexican, Pue	Specify Yes or No- no Rican, etc.)		ice - America ack, White, e	etc.
21215-0036	within 72 hou lene. than *natura the Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	during most of we	orking	16b. Kind of E Floor Compa	Cover	
	ld be filed ental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last) James Lucas Ell	iott				Stevens			
Maryland	d 2 shoul	Ė	19a. Informant's Name/Relationship (T) Allen T. Elliott,		1		t and Number or F	dural Route Number			Code)
Baltimore,	ages 1 an ont of Heal it: If item 2 y or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	20b. Place of Dispo	osition (Name of matory or other pla	ice)	Date	20c. Location	- City or To	
Baltir	permit. P Departme Importan eny injur		21. Signature of Funeral Service Licens		2:	2. Name and Addr	ess of Facility G	asch's Fu enue, Hya	neral	Home,	P.A.
14.5	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ne cause on each line a. A Hums	ne death. Do not en	0 1	ing, such as cardia	1	rest. Distera	esl	Approximate Interval Between Onset and Death
8760,	cate be execu ed physician and the burial-trar sit	dical Exan iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):				1810		
P.O. Box 68	death certifi e attending od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	ey .			ate of deliver	ry Day Year
	Se un eq	ρ	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	inderlying cause gi	ven in Part I.	23e. Did to			e cause of death?
Il Records,	The law ate has b page 2 si	Completed						24a. Was a autop perfor 10XYes	sy	Were autop prior to com death?	sy findings available apletion of cause of
f Vital	Physician: Th this certificate ral director, page	To Be	25. Was case referred to medical examiner? 1 ∑ Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 XER/Outpatie	nt 3 DOA Ot	har	eath (Check only or Home 5 Resid		her (Specify,)
ion of	Attending Ph r death. ector: Atter th by the funeral	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wo	iry at ork?] Yes 2 □ No	28d. Describe h	ow injury occu	rred	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rural	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire- completely filled in by	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	h occurred at the to vestigation, in my	ime, date and place opinion, death occ	e, and due to the durred at the time, o	ause(s) and materials	anner as sta , and due to	ited. the cause(s)
)	To th To th comp	Me	29b. Signature and title of certifier	M			se number	2	29d. Date signi Fe bru a		
0	(15)	14	30. Name and address of person who c	om Wed cause of dea		Print)		altimore,			
5	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar	's Signature		acce, b	C. C.HIVLE	, inty	2.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2004 07584 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Earnest Leroy Eure 1655 February 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 Q M 2 □ F 88 Yrs. March7, 1915 Director Washington DC 578 30 8635 Usuat Residence of Decedent ited within 72 hours after death with the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Itams 23a or 28a-f ahov other traumatic avant, the Mudical Exact in an intest to notified at Director 1 Yes 2 □ No Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2711 Millvale Avenue 20747 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3X Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Park Ranger 10th U.S. Park Service permit. Pages 1 and 2 should be file Department of Health and Mental Hys, Important: If item 27 is marked other any injury or other traumatic avenual once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Eure Mary Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Green/nephew 2204 East Spring Place Landover, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l Cem. 3-1-2004 Arlington, VA 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signatur y of Funeral Service Licensee, Ouc 4308 Suitland Road Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final **Physician** Sun Menning disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 3□ DOA this After thi 27. Manner of Death 28c, Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No d in by the 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055120 Feb 18 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1328 Son them suche SE Suite 310 Washington De 20032 Kichard Valmer 31. Date filed (Month, Day, Year) . Registrar's Signature State 1 9 2004 Registrar

ysician Viedical Kaminer		Registrar Amend # 1. Per MEO PGC	Ce			() ()	+ 0758
Medical		Decedent's Name (First, Middle, Last)	cr	artment of Health and I rtificate of Death		th	3. Time of Death
. *	4	RODNEY GENE EVANS La. Facility Name (If not institution, give street and num Fort Washington Medical	Center	4b. City, Town, or Location of Death FORT WASHINGTON If Under 1 Year If Under 24 Hrs.	1	4c. County of Dea	George's
eral ector		5. Social Security Number 213-36-1671 Sual Residence of Decedent	7. Age (In yrs. last birthday, 64 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, MAY 30, 1		rthplace (State or Foreign country) RGINIA
diffied at		10a. State 10b. County MD PRINCE GEORGE'S	10c. City, Town or L ACCOKEEK				10d. Inside City Limits 1 ☐ Yes 2 🙀 No
rinermust by natified	al Dire	10e. Street and Number 15501 HELEN DRIVE	dent Ever in U.S. 13.	10f. Zip Code 20607 Was Decedent of Hispanic Origin? (S	τ	J.S.A. 14. Race - Am	
Examinar I by Fund	2	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced 12. Was Dece 11 Yes 14 Fyes 15 Yes 17 Yes 18 Yes 18 Yes 18 Yes 19 Yes 10 Yes	2 □ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 🌠 No Specify:	o Rican, etc.)		
vent, its Madical Exertiner must be nutified at 3a Completed by Funeral Director	mpleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1 5+	-4or 5+) (Give	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) NESS OWNER		16b. Kind of Busines	
event,	00	17. Father's Name (First, Middle, Last) FREDERICK JEAN EVANS			ne (First, Middle, i		TIMBTING
2		19a. Informant's Name/Relationship (Type, Print) CHOON SIL EVANS - WIFE	1550	ing Address (Street and Number or Rull HELEN DRIVE, ACC	COKEEK, M		
eny injury or other tr once.		20a. Method of Disposition Language Burial 2 Cremation 3 Removal from 9 14 Donation 5 Other (Specify) 21. Signature From rail Cremation	NATTONAL MEMORIAL	matory or other place)	17/04	FALLS CHU	RCH, VIRGIN
once.	-	23a. Part 1. Exter the disease, or complications that c shock, or heart failure. List only one bause on e	74	482 LEE HIGHWAY, 1	FALLS CHU	JRCH, VIRG	INIA 22042
cian Iical iiner		Immediate Cause (Final disease or condition resulting in death)		T wand to Hand			Interval Between Onset and Death
burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence of):				
tached for use as the but		in the past 12 months?	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of d Month	alivery Day Year
i g	2	Part II. Other significent conditions contributing to de	eath but not resulting in the	underlying cause given in Part I.		bacco use contribute es 2 ☐ No 3 ☐ F	to the cause of death? Probably 4 Unknown
page 2 should	Completed				24a. Was a autop: perform	sy prior to	
To Be	lo Be	27. Manner of Death 28a. Date	npatient 2 ER/Outpatie of Injury (1/1/1) 28b. Time h, Day ear) Injury	ent 3 DOA Other: 4 Nursing H		ence 6 Other (Sp	ecify)
d in by the funer	Certification:	2 Accident investigation 2 3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, farm, sing, etc. (Specify)		SUBJECT 28f. Location (S City or Town ACCO VEO	SHCT SELF itreet and Number or I m, State) 15500 [1	Rural Route Number,
	Medical C	(Check only 2 Medical Exeminer: On the b	best of my knowledge, dea asis of examination and/or in her stated.	ath occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the curred at the time, d	cause(s) and manner added and place, and di	as stated. ue to the cause(s)
dia	M	29b. Signature and title of certifier	A.	29c. Licanse number		29d. Date signed (Moi February 1	
		170K M. 119VS.	e of death (Item 23a) (Type W (1)). egistrar's Signature	^{9, Print)} 111 Penn Stree	et, Balti	more, Mary	land 21201

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Maryla		artment of H			giene Reg. No. 20	با 0 ا	07586
Physici	an	Decedent's Name (First, Middle, Last)		•			2. Date of De. Month	ath Day	Year	3. Time of Death
/Medic Examin	al	Chester Arthur 4a. Facility Name (If not institution, give s		•	4b. City, Town, or	Location of De	Februar eth	y 4 20 4c. County	004 of Death	1:29 A ^M
		Holy Cross Hospi 5. Social Security Number 6. Sex		land himbertani	Sil.v	ver Spr				gomery
Funeral Director			M 2□F 7. Age (iii y)s	s. last birthday) 9 Yrs.	Months Days	Hours Mi		y, Year)	Country)	e (State or Foreign ginia
and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				-	Inside City Limits
e Mary la-f sh	ctor	Maryland Prince G	eorge's		Hyattsvi	ille				1X Yes 2 □ No
with the	Director	10e. Street and Number	#2224		10f. Zip Code	2070		10g. Citizen of V		
death ms 23	Funeral	9224 Edwards War	2. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi	2078: spanic Origin?	Specify Yes or No- erto Rican, etc.)	14. Race	ted Sta e-American	Indian,
ING 21215-0035 be filed within 72 hours after death with the Maryland hal Hyglene. d other than "natural", or items 23a or 28a-f show event. I've Medical Exam partnershe troulling at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 季 Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give	ŀ	fYes, specify Cubai 1 □ Yes 2[X] No	n, Mexican, Pui Specify:	erto Rican, etc.)	Blac Specify	k, White, etc. Blac	
Maryland 21215-0035 d 2 should be filed within 72 hours af th and Mental Hyglene. 7 Is marked other than "natural", or traumatic event, the Medical Extra	ted b	15. Decedent's Educ			ient's Usual Occupa		unsking	16b. Kind of Bu		
ING 21215- be filed within 72 tal Hygiene. d other than "nat event, I'm Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done d DO NOT use retired,)				
d Z filed v Hygie other t		17. Father's Name (First, Middle, Last)	2		Taxi Ca		ame (First, Middle,		Lf-Emp	Loyed
farylan 2 should be 1 and Mental 1s marked raumatic ev	To Be	Overton Euban	ks				Tessie	tollive	er	
Marylc d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship (Type			-		Rural Route Numbe			
N -		Chester A. Euban	20b.	Place of Dispo	sition (Name of		Ct., Sil	ver Spri 20c. Location -		
Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Lee's	natory or other place Cremator		18/2004		nton,	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or other		21. Signature of Funeral Service License	· 4 -	22	. Name and Addres	s of Facility	Stewart 1			
40280	V. 1	23a. Part). Enter the disease, or complic	cations that caused the dea	ath. Do not ent			ac or respiratory ar		Ap	proximate
Pnysician /Medical	36	shock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Cardiopu		Arrest				Int Or	erval Between nset and Death
Examiner		D	Due to (or as a conse Cerebral		tion					
ed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse							
60, be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):						
ate ate	dical	d.						_		
BOX 68 eath certific attending p	/Мес	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregr					23d Date	e of delivery	
HECONDS, P.O. BOX 6 The law requires that the death certific the has been signed by the attending to	Physiclan/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)	-		Mor	,	y Year
that th	y Phy	Part II. Other significant conditions conf	tributing to death but not re	sulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contr	ibute to the c	ause of death?
COTGS, P w requires that s been signed to should be deta	ted by	Hypertension					1 □ Y	es 2 🗆 No	3 ☐ Probably	4 Nnknown
II KECOTGS, The law requires t cate has been signe page 2 should be o	Completed	Diabetes Mell	litus Type I	<u> </u>			24a. Was a autop	an 24b. V sy p med? d	Vere autopsy rior to comple eath?	findings available etion of cause of
	Be Co	25. Was case referred to medical				26. Place of D	1 ☐ Yes eath (Check only or	2X No 1	☐Yes 2☐] No
dis y	To B	examiner? 1 Tes 2 No		ER/Outpatien	t 3□ DOA Othe		Home 5 ☐ Resid		or (Specify)	
		27. Manner of Death 1X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b, Time of Injury	28c. Injury Work	at	28d. Describe h	ow injury occurre	ed	
DIVISION I or Attending after death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At it building, etc. (Spec	nome, farm, stra ify)	eet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural Ro	oute Number,
Hospital or Hospital or 14 hours afte Funeral Dis tely filled in		29a. Certifier 1 Acertifying Physi	ician: To the best of my kn		occurred at the time	a data and pla				
Hos Fur ely	Medical	(Check only 2 Medical Examin	er: On the basis of examinand manner stated.	ation and/or inv	estigation, in my op	inion, death oc	curred at the time, o	late and place, a	nd due to the	cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	0		29c. License		2	29d. Date signed		
((10)		30. Name and address of person who cor	inpleted caus of dath /lto	m 23a) (The		52261		Februa	ry 5,	2004
(10)		Alan R. Segal			ircle, Si	lver Sp	ring, MD	20906		
Sta Registr		31. Date filed (Month, Day, Year) FEB 2 4 2004	32. Registrar's Sign	eture						

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 **Physician** 2004 8:25P.M. Ellis John /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Chevy Chase MAnor Care Chevy Chase If Under 1 Year If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Country)
Brony, N.Y. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 12XM 2□ F 70 Yrs Director 134-26-4199 02 06 Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-1 show the Medical Examiner must be notified at YE Yes 2 □ No Director Washington D.C. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 220 Madison Street, N.W. 20011 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1型Yes 2□No 1954-If Yes, Give Year or Dates: 1956 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2√ No Specify: þ 3 ☐ Widowed 4 X Divorced 1956 Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry New York Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wit Depertment of Health and Mental Hygienc Important: If item 27 is marked other the any injury or other traumetic event, the once. 2 yrs. Correctional Officer Dept. of Corrections 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John E. Ellis, Sr. Leona Hanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy A. Ellis Daughter 4550 Strutfield Lane Alexandria, VA. 22311 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State emetery, crematory or other place! 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-28-04Alexandria, VA. Metropolitan 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 Marshall 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours efter death. physician end s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the attending pl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobscco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Tinknown δ cate hes been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yas 2 10 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1-Natural ours efter death. erel Director: Aff filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fil (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunika Bhogaile 1220 A East Joppa Rd, Swif 230 Dowson, M121286 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 6 2004 Registrar

DHMH 16 Rev 6/95

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			1 - For AMFND#26 per phy. Registrar 2/24/04 AAOO HE	State of Maryland		rtment <i>tificate</i>			nd Me		jiene , eg. No. ⁽	2001	07589
			Decedent's Name (First, Middle, Last)							2. Date of Dea Month		Yeer	3. Time of Death
ı	Physicia /Medic			chko						Februar			<u></u>
3	Examin	er	4e. Fecility Name (If not institution, give str 631 Magothy View			Arno	ld	Location of				ounty of Dea	undel
	Funeral Director		5. Social Security Number 6. Sex 140–16–7276	7. Age (In yrs. las N 2☆F 81	t birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min	B. Date of Birth (Month, Day Sept. 1	6, 1		nthplace (State or Foreign country) IEW Jersey
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City,	Town or Loc	ation							10d. Inside City Limits
	Maryla	tor	MD Anne Aru	ndel A	rnold								1 Yes 2 XNo
	with the	Funeral Director	10e. Street and Number 549 Bay Dale Court			10f. Zip 0		21012		1	-	en of What C	ountry?
	eath v	eral		2. Was Decedent Ever in U.S.	13. V	Vas Decede			in? (Spec	ify Yes or No- ican, etc.)		4. Race - Am	erican Indian,
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Evantiae must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates:		Yes, specif			, Puerto R	ican, etc.)		Black, Wh	_{White}
21215-0036	72 hou	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced (Give	kind of work	c done d	urina most	of working	9	16b. Kin	d of Busines:	s/Industry
121	within ane. than	idu	Elementary/Secondary (0-12)	College (1-4or 5+)		Vice		; sident	+		Star	ndard '	Tools
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<u>lan</u>	uld be Vental irked itic ev	To Be	Simon Yablonicky							abloni			
Maryland	alth and I	·	19a. Informant's Name/Relationship (Type Suzan A. Chmiel/Dau					nd Number 7 View		Route Number VE Ai		Town, State,	
Baltimore,	Pages 1 a nent of Hea ant: If item ary or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	CON	ce of Dispos netery, crem 7etera	atory or oth	her place	ery Fe	ebrua 200	ry 23,		ation - City o	r Town, State
Baltir	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 2008.	ı	21. Signature of Funeral Service Licenses	2/1	Ba	Name and	Addres	s of Facility Sons, Ltchie	, P.A	. Seve	erna	Park 1	Funeral Home MD 21146
9	X · *		23a Pert1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the death.	Do not ente	er the mode	of dying	, such as c	cardiac or	respiratory arr		LCLLIY	Approximate Interval Between Onset and Death
)* _3	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque		AWZE	EK	01	0 1	ARY			16 mounts
	bed isit	liner	Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ince of):								
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687	0 0 0	edic	d.										
Box.	death cer le attendir ed for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. II yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	leath 3□	Ectopic pre Other (spe					2	3d. Date of de Month	elivery Day Year
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ord	v require been si should I	eted								1 U Y		_	
al Records,	The lay ate has page 2	Completed								24a. Was a autop perfor	SV	prior to death? 1 \(\text{Ye}	
Vital	Physician: The this certificate ral director, page	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	* 3□ DO	Othe	25.	of Death	(Check only or		X Other (Sn	ecity Daughter's
o	Affer Affer	-	1 Yes 2 No 27. Manner of Death Natural 5 Pending Natural investigation		28b. Time of Injury		Bc. Injury Work	at	21	Bd. Describe h			Residence
Division	Atten deat ctor: y the	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, larm, str	eet, lactory,	, office		2	81. Location (S City or Tow		l Number or l	Rural Route Number,
_	Hospita 4 hours Funeral	edical Co		ician: To the best of my know er: On the basis of examination and manner stated.									
	To the within 2 To the comple	Me	29b. Signature and title of certifier		^	29c.	Liceose	number	/ 1		29d. Date	signed (Mor	nth, Day, Year)
	- » F O		> texen	LXUR M	1)		1)	103	64		2	11911)4
			30. Name and address of person with con	TOPATE WD	23a) (Type	Print) SES 70	ATE	E RD	300	Ami	4202	5Wi	12/401
	St Regist	ate rar	31. Date liled (Month, Day, Year)	32. Registrar's Signatu	IT A	Local	20						,

			1 - For AMEND#26 Per P. State Registrar AAOO HEALTH 1. Decedent's Name (First, Middle,	DEPI. 2/23/0	Marylan 14 CMH	d / Depa <i>Cer</i>	artment of H	lealth and Death		Reg. No.	
	Physici /Medic		William Fairle	•					Februar	Day Y	3. Time of Death 004 11:30p M
	Examir Funeral Director		4a. Facility Name (If not institution, Chesapeake Hosp 5. Social Security Number 214-24-5571	oice House	Age (In yrs. 1	last birthday) Yrs.	4b. City, Town, or Linthi If Under 1 Year Months Days		8. Date of Bir	th 9 ly, Year)	Arundel Birthplace (State or Foreign Country)
	το	or	Usual Residence of Decedent 10a. State 10b. County	Arundel	10c. City	y, Town or Lo	cation		Dec. 2	3, 1926	MaryLand 10d. Inside City Limits 1 □ Yes 2√2 No
	death with the Maryland ms 23s or 28e-f show I must be notified at	Funeral Director	10e. Street and Number 974 Forest Driv		A	LIIOLU	10f. Zip Code	012		10g. Citizen of Wha	
920	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28e-f ahow any injury or other treumatic event, the Medical Examiner must be notified at ance.	þ	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceded Armed Force t TYPes 2[If Yes, Give Year or Dates	s? ⊒ No	11	Vas Decedent of Hi f Yes, specify Cuba □ Yes 2⊠ No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		American Indian, White, etc. White
21215-0036	d within 72 ho piene. r than "natur I'va Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12)	Education grade completed) College (1-4o		16a. Deced (Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired man/Contr	during most of wo l)	rking	16b. Kind of Busin	ness/Industry
Maryland 2	ould be filed Mental Hyg varked other vatic event,	To Be C	17. Father's Name (First, Middle, L John Fairley					Anna M	Marie Las		
	and 2 sh salth and n 27 is m er treum		19a. Informant's Name/Relationshi			1000	g Address <i>(Street a</i> 74 Forest	NAME OF THE PARTY	ural Route Numbe	er, City or Town, Sta	
Baltimore,	ment of He tant: If Iten		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Specific Control of	ecify)	C	lace of Dispos emetery, cren	sition (Name of natory or other place) Ige Mem.	Febr	ruary 18 2004	20c. Location - Cit	y or Town, State
Baj	Depar Impor any in		21 Signatury of Funeral Service L	Certisge		Ba	Name and Address Arranco & 95 Gov. R	Sons F	.A. Sev lwy. Sev	verna Parl Verna Parl	k Funeral Home k, MD_21146
	Physician /Medical Examiner	liner	23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a	ed the death line. as a consequ	uence of):	er the mode of dying		c or respiratory ar	rest,	Approximate Interval Between Onset and Death
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	ian/Medical Examiner	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	2 Fetal	ncy death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
s, P.O.	res that the death certi igned by the attending be detached for use a	by Physician/M	1 Yes 2 No 9 Unknown Part II. Other significant condition	4 Pregnant 9 Unknown s contributing to death			Other (specify)	on in Part I.	23e. Did to		te to the cause of death?
Record	The law requi ate has been s page 2 should	Completed							24a. Was autop	an 24b. Wer sy prior med? deat	Probably 4 Unknown Be autopsy findings available to completion of cause of h? Yes 2 No
Division of Vital	To the Hospital or Attending Physician: The within 24 hours alter death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident 5 Pending investiga	28a. Date of In (Month, E	jury	ER/Outpatient 28b. Time of Injury	28c. Injury Work	r: 4 ☐ Nursing H			Specify)Hospice
Divis	ital or Attendirs after deathers birector:	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of I building,	etc. (Specify,)	et, factory, office		City or Tow	n, State)	r Rural Route Number,
	To the Hospital of within 24 hours all To the Funerel D completely filled in	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best taminer: On the basis and manner:	or examinati	vledge, death ion and/or inv	occurred at the timestigation, in my op	e, date and place inion, death occu	e, and due to the d rred at the time, o	ause(s) and manne date and place, and	r as stated. due to the cause(s)
,	To the within To the comp	Σ	29b. Signature and little of certifier	Nolle	5		29c. License	1819		29d. Date signed (M	104
		10	Matther	To completed cause of	ten	132	Holida-	CT	Anns	pelis M	D 2/401
	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 2-3		trar's Signati	ure	Bell 1				

			1 - For State Registrar	State of	Marylan		artment <i>tificate</i>			nd Menta		ene Z	004	0/59
	Physici /Medic		Decedent's Name (First, Middle, Las Barbara Kelly Fi	•						Mo	of Death oth Druary	Day	^{Yeer} 2004	3. Time of Death 3:30 P ^M
	Examir		4a. Fecility Name (If not institution, give 2826 Fennel Road	street and numb	oer)		, ,		Location of ewater				ty of Deeth Arunc	lel
	Funeral Director		5. Social Security Number 6. Se 054-44-8485	x	Age (In yrs. 55	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Min. (Mo	of Birth oth, Day, Y	^(ear) 2, 19	Coun	lace (State or Foreigr atry) W York
	Maryland -f show lied at	tor	10a. State 10b. County Maryland Anne Ar	undel	10c. Cit	y, Town or Lo	cation	Ed	gewate	er			1	0d. Inside City Limits
	3a or 28a	Il Director	10e. Street and Number 2826 Fennel Roa	đ			10f. Zip C	ode	21037	7	100		What Coun	try?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural; or Items 23s or 28s-f show stry figury or other traumatic evant, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceded Armed Force 1 Tes 2 If Yes, Given Year or Date	es? No	'	Vas Decede Yes, specif	y Cuba	spanic Origin, Mexican,	in? (Specify Ye Puerto Rican, e	s or No-		ace - Americ ack, White, ify: Wh	
9500-61212	ithin 72 ho ne. nen "natur Neutical	Completed	15. Decedent's Edi (Specify only highest grade Elementary/Secondary (0-12)	ucation le completed) College (1-4	or 5+)	(Give	OO NOT use	done d retired	luring most o)	of working	16		Business/Inc	dustry
yiand 21	uld be filed w lental Hygier rked other th	To Be Cor	17. Father's Name (First, Middle, Last) Edward Joseph Ke	2 lly			Home	make	18. Mother's	s Name (First,		iden Suma	Home	
, Mar	and 2 shousalth and Malth		19a. Informant's Name/Relationship (T) Robert Funk/husb			1				or Rural Route Edgewat		-	n, State, Zip 1037	Code)
bartimore	nit. Pages 1 and artment of Health ortant: If item 27 injury or other ti		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signatur Fred Service Licens			/)	s Cem	ete:	ry 2/	Date 21/2004 John M	Ar	napol	- City or To Lis, M	D
ă	Deparation of the control of the con		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that cau	ised the death	14 سع	7 Duk	e o	f Glou	ıcester	St. A	Innapo	olis,	MD 21401 Approximate Interval Between
)	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Br	east (-							Onset and Death 3 years
3/60,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	as a consequ									
O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2★No 9 □ Unknown		n 2 ∏Fetal it at time of de	death 3	Ectopic preg Other (spec						ate of deliver	ry Day Year
Sorus, P	The law requires that the tee has been signed by thoage 2 should be detache	by	Part II. Other significant conditions co		th but not resu	ulting in the un	derlying cau	se give	n in Part I.	23e				e cause of death?
ž L	The larate has	Completed								_	. Was an autopsy performed Yes 2 🗵	ar	Were autop prior to com death? 1 \(\subseteq \text{Yes} \) 2	sy findings available apletion of cause of
V 113	Physician: this certificanal director,	o Be	25. Was case referred to medical examiner?	lospital:				Othe		f Death (Check			_	
5	g Phy er this eral d	H 1	1 ☐ Yes 2 XNo 27. Manner of Death	28a. Date of I	Injury	ER/Outpatient 28b. Time of		. Injury Work	4 🗀 Nursi	ing Home 5X		e 6 Ott)
NISION NISION	al or Attanding F after death. I Director: After d in by the funer	Certification:	M⊠Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	(Month,	Day Year)	Injury	М	1 🗆 Y	? ′es 2 □ No					Route Number,
Ś	spital or cours after neral Direction in filled in E		29a. Certifier 1⊠ Certifying Phy	building,	, etc. (Specify	vledge, death	occurred at	the time	a date and r	City	or Town, S	State)	20001 25 612	tod
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	(Check only 2 Medical Examione) 29b. Signature and title of centifier	ner: On the basi and manner	s of examinat	ion and/or inv	estigation, in	ту ор	inion, death	occurred at the	time, date	and place,	and due to	the cause(s)
	F ₹ F ŏ		·	5. NO	mol.		I			1301		2/1	1	2004
			30. Name and address of person who co Kevin B. Knopf, I				,	An	napol:	is, MD	2140	1		

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)
FEB 2 0 2004

32. Resistrar's Signature

			1 - For State Registrar	State of Maryland	d / Depa		Health and	Mental Hyg		
	Dhusisi	-	1. Decedent's Name (First, Middle, Last	1)				2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medi		Edna Bell Fry					January	31, 2004	7:04 AM ^M
	Examir	er	4a. Facility Name (If not institution, give				n, or Location of Deat	h	4c. County of Dea	
			St. Mary's Nursin 5. Social Security Number 6. Se		n n é frûndh aln i i	Leona:	rdtown ar If Under 24 Hrs	O Date of Birth	Saint 1	
	Funeral Director			7. Age (In yrs. In ☐ M 2 🖾 F		Months Day		(Month, Day,	, 1911 Man	nthplace (State or Foreign country)
			Usual Residence of Decedent	, , , , , , , , , , , , , , , , , , ,				Dec. 10	, IJII Hai	Lyland
	how		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
:	Ba-f s	cto	Maryland Saint Ma	ary's Lec	onardt	own				Y Yes 2 □ No
;	or 20	Dire	10e. Street and Number			10f. Zip Code	Э	10	Og. Citizen of What C	country?
	s 23s	ral	23300 Hollywood I		2 10	2065			U.S.A.	
	ltem Item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of If Yes, specify Ci	of Hispanic Origin? (S uban, Mexican, Puer	o Rican, etc.)	14. Race - Am Black, Wh	
36	irs aff		3 Widowed 4 □ Divorced	1 ☐ Yes 2 ♠ No If Yes, Give Year or Dates:		1□Yes 2√∏N	lo Specify:		Specify:	Thete
21215-0036	within 72 hours atter death with the Maryland ene. Than "natural", or tlems 23a or 28a-f show he Madical Examiner must be notified a	Completed by	15. Decedent's Edu	ucation	16a. Dece	dent's Usual Occ	cupation ne during most of wo ired)		16b. Kind of Busines	√hite s/Industry
215	thin 7	npie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	ired)	King		
S	ygien ygien her th	S	12th Grade		Вос	k Keepe				e Dealership
pu	tal H d off	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, N		
<u>\Z</u>	ould Men narke natic	P _C	Enoch Archibald I		101 14 11			eanor Ga		
Maryland	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Beginner that and the than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.		19a. Informant's Name/Relationship (T)	•					City or Town, State,	
	1 and Healt em 2	11	Eleanor Regina Ler			O Medite natory or other p			ardtown, N	
Baltimore,	ages ant of t: If it		1 Trial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Tellioval ilotti State		natory or other p			•	
III.	artme ortan injur	1	21. Signature of Funeral Service Licens	1					Funeral H	m, Maryland
Ba	Deparent Dep		Elyd N. Br	/ -					rdtown, MI	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications hat caused the death						Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	Respiratory						Onset and Death Hours
	/Medical		resulting in death)	Due to (or as a consequ		are				HOULS
	Examiner		Sequentially list conditions	cardiopulmo		Failure				Days
	D =	ner	Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence or).					
	and and trans	Examiner	that initiated events resulting in death) Last	c. Coronary An		Disease				Years
760,	eath certificate be executed attending physician and for use as the burial-transit	calE		Doe to (or as a consequ	ence ory.					
687	phys phys s the			d						
Вох	certit nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23d. Date of de	slivery
m	death e atter	iclai	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnar Other <i>(specify)</i>			Month	Day Year
0	that the de ed by the detached	hys	9 Unknown	9□ Unknown						
œ,	requires that the neen signed by the hould be detache	oy P	Part II. Other significant conditions co	ntributing to death but not resu	lting in the u	nderlying cause (given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
rd	w require been sig should b	ed						1 ☐ Ye	s 2 No 3 P	robably 4XJUnknown
Records,	2 S S	Completed by						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
_ ,	pa ate	MO.						perform	ed? death?	s 2 No
Vital	Pnysician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one		
of	S w D	၉	I Tes X No		ER/Outpatier	I 3 DOA	- 20		nce 6 Other (Spe	ecify)
	After Aune	ion:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W		28d. Describe how	w injury occurred	
isio	Attending r death. sctor: After by the fune	icat	3 Suicide 6 Could not be	28e. Place of Injury - At hor	ma form ste		☐Yes 2☐No	29f Location (Ste	eet and Number or R	tum I Pouto Alumbos
	after Direction by	Certification:	4 Homicide determined	building, etc. (Specify,)	еец, тастогу, оптс	.e	City or Town,		urai Houte Number,
	To the Hospital of Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier X Certifying Phy	sician: To the best of my know	vledge, death	occurred at the	time, date and place	and due to the car	use(s) and manner a	s stated.
:	1 24 F	Medical	(Check only 2 Medical Exami	ner: On the basis of examinati	on and/or in	vestigation, in my	y opinion, death occu	rred at the time, da	te and place, and du	e to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the the	Me	29b. Signature and title of certifier		111	29c. Lice	nse number	29	d. Date signed (Mon.	th, Day, Year)
			James	T. MANVOS	2///	1	D06419		February	1. 2004
0	0		30. Name and address of person who co	ompleted cause of death (Item	За) (Туре,	Print)	-00 (1)		Lebidary	1, 2007
الحا			James P. Jarboe,			tch Road	d Hollywoo	d, Maryla	and 20636	
	Sta Registi		31. Date filed (Month, Day Year)	32. Registrar's Signati	ure	Social	a			

		_1	For Stata Registrar	State of Maryland		tificate of L			Reg. No. 200	4 07593
	Physicia	ın	Decedent's Name (First, Middle, Last)	Veronica Ma	ary Fei	rguson		2. Date of Dea Month January	Day Yea 29, 2004	3. Time of Death 11:30 P M
,	/Medic Examin	_	a. Facility Name (If not institution, give :	street and number)		4b. City, Town, or	Location of Death		4c. County of De	eath
	Examin	3 1	St. Mary's Nursing			Leonardt	own		St. Mary	's
	Funeral		5. Social Security Number 6. Sex		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day November	h 9. E y, Year)	Birthplace (State or Foreign Country) reland
	Director	-	Usual Residence of Decedent					november	24, 1909 1.	retailu
	aryland show	_	10a. State 10b. County		, Town or Lo					10d. Inside City Limits 1X Yes 2 ☐ No
	89-f	ecto	Maryland St. Mar	y's Le	eonard	10f. Zip Code			10g. Citizen of What	
	with the	吉	10e. Street and Number			Toi. Zip Code	20650		USA	County!
	eath	era	21585 Peabody St:	12. Was Decedent Ever in U.	S. 13. V	Was Decedent of His f Yes, specify Cubar		ecify Yes or No-		merican Indian,
326	be filed within 72 hours after death with the Maryland Hygiene. d other then "natural", or items 23e or 28e-f show event, it a Madical Exertinal cast to notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cubar 1 □ Yes 2 🛣 No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify: W	
5-0036	2 hou		15. Decedent's Edu (Specify only highest grad	cation completed)	16a. Deced	lent's Usual Occupa	ation furing most of work	ina	16b. Kind of Busine	ss/Industry
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done d DO NOT use retired,)	3	Notional	Ichoratory
.N	filed wi Hygien yther th	S	17. Father's Name (First, Middle, Last)	2	нои	sekeeper	18 Mother's Name	/First Middle	Maiden Sumame)	Laboratory
_	ibe fii ntai H ed otl	Be		Thomas McCabe				Leen Bre		
چ	should be and Mental semarked o umatic eve	၉	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street a			er, City or Town, State	e, Zip Code)
<u>B</u>	od 2 s lith an 27 is r treu		Kathleen E. Roth/		47834 (Cross Mannon	r Road, St.	Inigoes,	Maryland 20	0684
altimore,	es 1 ar of Hea of Hea of Hea of Hear r other	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. P	lace of Dispo emetery, crer	sition (Name of matory or other place	a)	Date	20c. Location - City	or Town, State
Ē	Page ment ent: If ury or		* 4 ☐ Donation 5 ☐ Other (Specify)	Holy		hre Cemeter	y	uary 2004	Coram, New	York
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic evonce.		21. Signature of Funeral Service Licens	broliner	Ma P	Name and Address attingley-Ga .0. Box 270	ardiner Fun , Leonardto	wn, Maryl	and 20650	
			23a. Part . Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death	n. Do not ent	er the mode of dying	g, such as cardiac		1	Approximate Interval Between Onset and Death
	Physician		Immediat Cause (Final disease or condition resulting in death)	Carolio	res	produce	smy	avs	est.	Onset and Dodni
	/Medical Examiner		resulting in death)	Due to (or as a consequence of the consequence of t		Den	relation			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence			Di c			
	cuted nd ransit	Examiner	that initiated events	Failu	re_	10	thinve	<i></i>		
90	iicate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as a consequ	uence of):					
68760,	physicate to physical	edlcal		d						
P.O. Box (Attending Physicien: The law requires that the death certif r death. r death. ector: After this certificate has been signed by the attending betor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3[Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	that the ed by detac	Ph	Part II. Other significent conditions co	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
ds,	quires n sign ald be	d by				. <u>.</u>		10	Yes 2⊡No 3⊡	Probably 4 Unknown
Division of Vital Records,	Гhe law requir te has been si age 2 should	Completed			<u>-</u>			24a. Was autop perfo 1 🗆 Yes	rmed? death	a autopsy findings available to completion of cause of n?
ital	en: rtifica tor, p	a	25. Was case referred to medical			-	26. Place of Deat			
>	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2	ER/Outpatier		4 Shursing Ho		dence 6 Other (S	Specify)
o uo	ding Pt th. : After the funeral		27. Manner of Seath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	yat k? Yes 2 ∐No	28d. Describe I	how injury occurred	
Divisi	l or Atter after dea Director	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)		reet, factory, office		28f. Location (3 City or Tox		r Rural Route Number,
_	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifying Phy (Check only one)	slcien: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 to the I complet	Me	29b. Signature and title of certifier			29c. Licenso	e number		29d. Date signed (M	onth, Day, Year)
	F ≯ F Ö) -DShe	ah		A	47066		1.30	04
-	38		30. Name and address of person who of Dr. A.D. Shah, Si				ing, Leon	ardtown	, Marylan	d 20650
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FFR 0 5	32. Registrar's Signa	ature					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** FERGUSON 11:25 PM ROSA FEBRUARY 21 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BAITIMORE BATTIMONE BON Secours Hosp, tal f Under 1 Year | If Under 24 Hrs. fonths Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 X F 86 05 Director 18 VIRGINIA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director BAITIMORE BATIMUIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 10, tel States move 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Efementary/Secondary (0-12) College (1-4or 5+) eachor chool 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BERNARD BOUINE MASON ပ 12 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FERGUSON AVE Husband) 710 N. Whitmore BALTIME Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 0 permit. Page Department c Important: If eny injury or GRUAON Jankins 4 □ Donation 5 □ Other (Specify) Cen. 28-04 BR Hone 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WH ARSTON FUNGERA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACCOMAC 23301 Approximate Interval Between Onset and Death Immediate Cause (Final PNUEMONIA **Physician** DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DISEASE ARTER DSCLEROTIC HEAR-1 UNENUWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit HYPERTENTION NNENOWN Due to (or as a consequence of): Box 68760, as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 0 Month Year Day 5 Other (specify) ☐Yes 2☐No P.0. be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, CEREIS RO-VASCUZAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DEMENTIA 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 🔀 No of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2. No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: Division 5 Pending 1 ANaturaf s after death.
I Director: A
id in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital VET Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D 23300 FEBRUARY 212004 BON BELOWRS HUST, 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) PATE2 SUDIAR. ST-BALTO MD Dr 2010W. BALTO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 5 2004 THUR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 100 [07595 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 7:00 A.M 02 Ort Dianna Jean Fleming /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cumberland

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. MEART DITAL egan 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country)

West Virginia 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🗷 F 10-Jul-1948 218-50-0778 Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland **Allegany** Frostburg 10e. Street and Number 19009 Kerr Road, SW 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 12 permit. Peges 1 end 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morris G. Green Jean Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19009 Kerr Road, SW husband James J. Fleming, Sr. Frostburg Maryland 21532-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Frostburg Memorial Park 23-Feb-2004 frostburg * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End stage Chrom's obstructive lung Disence Immediate Cause (Final disease or condition resulting in death) 2 months **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Heart tailwa 1 ☐ Yes 2 ☐ No 3 Probably 4 DUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 2 X No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 2 D0055325 Feb 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mas. Frostburg 48 Turn MD 21532 wonsock shin 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 3 2004 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 000

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	/Medical	40 Facilia Name (March in sta							wn, or Lo	cation of Death	4c. Count		20.55	
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	Director	Usual Residence of Decedent								0 7 / 0 4 / 3		пату	Tanu	
	and *	10a. Stete 10b. Cou		10c. City, Tov	vn or Loca	ition						1	0d. Inside City Li	imits
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	led within 72 hours after death with the Maryland Sylene. We than "natural", or items 23s or 28s-f show it, the Medical Examiner must be notified at Completed by Funeral Director	1047 Braddoo						21502			USA			
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ē	1 and 2 Haalth am 27 i	20a. Method of Disposition		20b. Place of	of Disposit	ion (Nem	e of			Date	20c. Location	- City or To	wn, State	
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	NIE ST	23a. Part1. Enter the disease shock, or heart failure. I	, or complications l'al	used the death. Do	not enter	the mode	of dyin	g, such as	cardiac o	r respiratory arr	est,	i	Approximate Interval Between	
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	that the de ted by the a detached t	Part II. Other significant cond	litions contributing to dea	th but not resulting i	in the unde	erlying ca	use giv	en in Part I.		23b. Did to	bacco use co	ntribute to	the cause of de	eath?
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<u>ra</u>	certificate rector, peg		ical					26 Place	of Death	(Check only on				
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			1 - For State Registrar	State of Maryla			nt of H te of L		nd Mer	ntal Hygie	/	004	07597
	Physicia	an	Decedent's Name (First, Middle, Last,	Olive Mae	Foote					Date of Death Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		7 1 0010	4b. Cit	, Town, or	Location of			4c. Count	y of Death	6.30
			Sacred He	art Hosp	1721	C	im		and		A	-11eg	
	Funeral Director		5. Social Security Number 6. Sec. 1214-07-3694	IN SING	rs. last birthday) 87 Yrs.	Month:	or 1 Year Days	If Under 2 Hours	Min. 8.	Date of Birth (Month, Day, Y		9. Birthp	
			Usual Residence of Decedent							April 10	, 1910	J	Maryland
	72 hours after death with the Maryland natural', or Items 23e or 28e-f show Item Examiner must be matified a	2	10a. State 10b. County		City, Town or L	ocation		_				1	10d. Inside City Limits 1 ☐ Yes 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Heath and Mantal Hygieral and the filed 27 is marked other than "natural", or items 23e or 28e-f shot or other treumatic event, the Modical Examiner must be notified at	Director	Maryland Al	legany		10f 7	ip Code	Lonac	oning	100	Citizen of	What Cour	
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36	s after	y Fu	1 ☐ Never Ma <i>rried</i> 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes		Specify:		,	Speci		
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and	ould be fi Mental H arked otl	o Be	17. Father's Name (First, Middle, Last)	n Wesley Fazenba	ıkar			18. Mother	rs Name (F)	rst, Middle, Ma.			
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	and 2	j	Carol King-	Daughter			3	0 Florid	dia Way	Lonaconi	n Md.	21539	
Baltimore,	permit. Peges 1 and Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1		 b. Place of Disposers cemetery, cre 	osition (N matory or	ame of other place	θ)	Date	20 oruary 18	c. Location	- City or To	own, State
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			23a. Part 1 Enter the disease, or complete ships, or heart lailure. List only o	ications that caused the d	eath. Do not en	ter the me	de of dying	g, such as c	St. Lor cardiac or re	spiratory and st	4d.215.	39	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	CUN GIS	tive h	ear	fa	11/4+	7				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):			- t I (1				1021010
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Вох	atter for u	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No	1 Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death 3	□Ectopic □ Other (:	pregnancy specify)					ate of delive lonth	Day Year
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Division of Vital Records,	has has	ldm								24a. Was an autopsy performe	d2	prior to co death?	psy findings available mpletion of cause of
ta	ician: Th certificate rector, pag	40	25. Was case referred to medical		<u>-</u>			26 Place	of Death (C	1 ☐ Yes 2 ☑ heck only one)	No	1 Yes	2□ No
Ž	dis y	To B	examiner? 1 Yes 2 No	lospital: 1 Inpatient :	2 🗌 ER/Outpatie	nt 3□ (Othe Othe			5 Residence	e 6 □Ot	her (Specif	iy)
o L	Jing Ph J. After th funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o		28c. Injury Work			Describe how	injury occu	rred	
isio	Attending r death. sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home farm of	M		Yes 2□N		Location (Street	t and Num	ber or Pur	al Route Number.
Di∨	spital or Attendours after death ours after death nerel Director: filled in by the	Certification;	4 Homicide determined	building, etc. (Sp	ecify)	reet, rack	ary, ornice		201.	City or Town, S		001 01 11010	ar rioute rumber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	calc	29a. Certifier 1 Certifying Phy	sician: To the best of my	knowledge, dea	th occurre	d at the tim	ne, date and	d place, and	due to the caus	e(s) and m	nanner as s	tated.
	To the Hos within 24 h To the Fur completely	Medical	one)	ner: On the basis of exam and manner stated.	mation and/of if				n occurred a				
<u> </u>	or with Co	-	29b. Signature and title of certifier	rent		2	9c. License	C 7-21					Day, Year)
	6		30. after and address of person who c	ompleted cause of death (Item 23a) (Type	Print)	UU	15)			STUAL		3004
(That		Deroit mee	VIV 14	4711	92er	Ro	1-12	L. C	Limber	dino	MI	S 12113
	Sta Regist		31. Date liled (Month, Day, Year)	32. Registrar's S	ignature 4	1	2.11	/					-

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004

07598 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** LILLIAN Y. FEINSTEIN **FEBRUARY** 19, 2004 2:19 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Yrs. Director APRIL 12, 1915 **NEW YORK** 089-10-2654 Usual Residence of Decedent death with the Merylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28e-f shov s notified at 1 XYes 2 □ No Director MONTGOMERY ROCKVILLE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23e or 6121 MONTROSE ROAD 20852 UNITED STATES Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. pemit. Peges 1 and 2 should be filed within 72 hours efter of Department of Health end Mental Hygiene. Inportant: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Madical Examine 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify. Specify: WHITE δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SALESPERSON RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FINKELSTEIN **GEVIRTZMAN** GUSSIE NATHAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1217 KENSINGTON RD., TEANECK, NJ 07666-2718 JEROME B. FEINSTEIN, SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STAR OF DAVID CEMETERY 2/22/04 N. LAUDERDALE, FL 21. Signature of Funeral Service Licenses DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. tlamust 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) INFARCTION Myo (fr)1.76 Examiner Examine anding physician end use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Due to (or as a consequence of). resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2XNo 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 XN0 this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ŏ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide A Hospital of 124 hours et a Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in manner as stated. 29a. Certifier edicai (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To tha P. within 2. 29b. Signature and title of Certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONIR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2004 Registrar

DHMH 16 Rev 6/95

			For Stata Registrar	State o	of Maryland / I	Depa <i>Cei</i>	artment <i>tificate</i>	of He	ealth a Death	and M	ental Hy	giene Reg. No.	2004	,	07599
			1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month	ath Day	Year		3. Time of Death
	Physicia /Medic		Margu	erite F1	orchinger						Februa				6:20P M
	Examin		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City, T	own, or	Location of	of Death		4c. (County of Dea	ath	
		1	9912 Marquette	Drive			Bet	thes	da			Mo	ontgome	ery	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th V Year)	9. Bi	irthpla Country	ce (State or Foreign
	Director		N/A	1 ☐ M 2 🛣 F	90	Yrs.	WORKIS	Days	110013		July 2	2,191	13 F	ran	
	P.	Ī	Usual Residence of Decedent		10a City Tay									100	I. Inside City Limits
	anylar show	_	10a. State 10b. County		10c. City, Tow	ni or LC	Cation							100	1 ☐ Yes 2 🛣 No
	Be-f s	cto	Maryland Montgo	mery		Bet	hesda							Ш.	
	or 2	Funeral Director	10e. Street and Number				10f. Zip (10g. Citiz	zen of What C	ountr	y?
	ath w	rai	9912 Marquette						817		7 17		ance		- Ladden
	tems	nue	11. Marital Status	Armed F		13.	Was Decede f Yes, specif	nt of His fy Cubar	spanic Ori n, Mexican	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.))- 1	14. Race - Am Black, Wh		
36	s afte	by F	1 ☐ Never Married 2 ☐ Marr 3 🏻 Widowed 4 ☐ Divorced	ied 1 □ Yes If Yes, G Year or D	2 X No ive		1 ☐ Yes 2	X No	Specify:				Specify: W	hit	e
8	be tiled within 72 hours after death with the Maryland ital Hygiene. id other than "naturel", or items 23e or 28e-f show event, Ital Medical Eracifier must be notified at	pe		t's Education		Dece	dent's Usual	Occupa	tion			16h. Kir	nd of Busines	s/Indu	strv
7 5	n 72 "na	Completed	(Specify only highes	st grade completed,		(Give	kind of work DO NOT use	done di retired)	uring mos	t of workir	ng	, 551 7 1			,
12	withi ene. than	mc	Elementary/Secondary (0-12)	College ((1-4or 5+)		iness					C.	lothin	g	
9	filed Hygi ther ant, I	ပိ	17. Father's Name (First, Middle,			200	211000			_	(First, Middle			a	
an	12 should be filed within h and Mental Hygiene. 7 is marked other than "ireumatic event, it is Me.	To B	Anatole Eicher						Vales	ska K	leinfe	1d			
<u></u>	shoul nd Me marl mati	1	19a. Informant's Name/Relations	hip (Type, Print)	191	b. Maili	ng Address (Street a	nd Numbe	r or Rura	Route Numb	er, City or	Town, State,	Zip C	tode)
Z	nd 2 :		Elisabeth Schar	en-Guivel	/Daughter	99	12 Mar	rque	tte I	rive	; Beth	esda	, MD 20	081	7
ā,	Specify: Who specify: Specify: Who specify: Specify: Who specify: Who specify: Who specify: Specify: Specify: Who specify: Specify: Who specify: Specify: Who specify: Specify: Specify: Who specify: Specify: Specify: Specify: Specify: Who specify: Sp														
<u>o</u>												tevill	0	MD	
⋣	artme orten injur		21. Signature of Funeral Service		Cilesa						ral an				
Ba	Dep any		1 (Litter	& Dow	W.						ral an				
			23a. Part1. Enter the disease, or	complications that	caused the death. Do								e g MD	P	oproximate
	Selection of the Control		shock, or heart failure. List Immediate Cause (Final			_								(nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a.	fetastatic (or as a consequence		ast Ca	ance	r					1 2	Years
н	Examiner			500 (0	(or as a consequence	Ol).									
		e e	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequence	of):								+	
	uted I Insit	듩	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S											
<u>,</u>	exect n and ial-tra	Examin	that initiated events resulting in death) Last	Due to	(or as a consequence	of):									
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical		d											
9	ificat g phy as th	edi												l	
Вох	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnancy birth 2 Tetal deat	h a[Ectopic pre	ananau				2	3d. Date of d		
Ď	death e atte d for	cla	in the past 12 months? 1 □ Yes 2 X No	4☐Preg	nant at time of death		Other (spe						Month	D	ay Year
0	that the de ed by the a detached	hys	9 Unknown	9□ Unki	nown							0-2			
٦,	requires that the veen signed by th hould be detache	by P	Part II. Other significant condition	ons contributing to	death but not resulting	in the u	nderlying ca	use give	n in Part I	*	23e. Did 1	tobacco us	se contribute	to the	cause of death?
rg	quire in sig uld b										10	Yes 25	No 3□f	Probab	oly 4 ⊟Unknown
8	3 11 0	Completed									24a. Was				y findings available of
Be	e he	E									auto perfo	ormed? 2 X No	death?	,	
of Vital Records,	ian: T rtificate stor, pe	0	25. Was case referred to medica	1					26. Place	of Death	(Check only				
5	Physician: this certific ral director,	To B	examiner? 1 ∐ Yes 2 🏋 No	Hospital: 1	Inpatient 2 ER/O	utpatie	nt 3 DO/	Othe	r: 4□Nu	rsing Hor	ne 5 X Resi	idence 6	S □Other (Sp	ecify)	
	g Ph er th		27. Manner of Death	28a. Date		Time o	f 28	c. Injury Work	at	2	28d. Describe	how injury	y occurred		
<u>o</u>	Attending I or death. ector: After by the funer	atio	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	igation	,, ,	,,	М		/es 2 □	No					
Division	Atte er de ecto by th	iţi	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Flat	ce of Injury - At home, f ding, etc. (Specify)	arm, st	eet, factory,	office		2	28f. Location (City or To	Street and wn, State)	d Number or F	Rural F	Route Number,
Ö	spital or Attendii ours after death. nerel Director: A filled in by the fu	Certification:	1		3. (-2.35.7)										
	To the Hospital within 24 hours a To the Funerel Completely filled				ne best of my knowledg basis of examination a										
	the H in 24 the Fi plete	Medical	one)	and ma	nner stated.	/									
·	To the within 2 To the complet	Σ	29b. Signature and title of certific		1//		29c.	License	number			29d. Date	e signed (Moi	nth, De	ay, rear)
)	0				111]	0003	3293			Febr	ruary 2	24,	2004
	W		30. Name and address of person										•		
_			Frederick Smith		4 Wisconsi	in A	venue	; Su	ite .	1300;	Chevy	Chas	se, MD	20	815
	Sta		31. Date filed (Month, Day, Year, FEB 24		Registrar's Signature	4	Spa	. 10	,						
E	Regist	rar	FED 24	4004	/		apo	ers							

MARGVERITE FLORCHINGER DOD/02-10-04 TOD/18:20

		ľ	1 - For State Registrar	State of Maryla			nt of He		d Mental Hy	giene Reg. No.	711114	07600
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Bernard Fridberg							.9-04		3:05 P. M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give s 9537 Clement Rd. 5. Social Security Number 579-12-1391		. last birthday) Yrs.	Si	lver S	Spring If Under 24 I Hours		Mo	ntgomery 9. Birth Cou	place (State or Foreign
	ס	tor	Usual Residence of Decedent	10c. C	ity, Town or Lo				10-10-2	- 4		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28a	Funeral Director	10e. Street and Number 9537 Clement Rd.			10f. Zi	Code 20910			10g. Citi	izen of What Cou	intry?
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examinal mail be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in N Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW		Was Dece If Yes, spe 1 Yes		panic Origin? Mexican, Pi Specify:	' (Specify Yes or No uerto Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
21215-0036	a within 72 ho jiene. r than "natur If a Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of wo DO NOT u	ise retired)	on ring most of	working		ography	ndustry
Maryland	hould be filed d Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, Last) Sigmund Fridberg 19a. Informant's Name/Relationship (Ty,	ge Printl	19h Mailir	a Addres		Marth	Name (First, Middle a Adler : Rural Route Numb			o Codel
altimore, Ma	permit. Pages 1 and 2 si Department of Health an Important: If itam 27 is r any injury or other traur		Karen Lieberman — 20a. Method of Disposition 1 월 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Daughter 20b. Ki	9537 Place of Dispo cemetery, cree ing Dav	Clem esition (Na matory or o	ent Rome of other place)	d. Sil	ver Sprin Date -22-04 Hines-Rina	ng, M 20c.Lo	ID 20910 ocation - City or T	own, State
m I	ded out of the control of the contro		23a. Part1. Enter the disease, or compliance, or heart failure. List only or Immediate Cause (Final	e cause on each line.	1. Ith. Do not ent	1800 er the mo	New H	ampshi	re Ave.,	Silv		ng, MD 20904 Approximate Interval Between Onset and Death
,760,	/Medical Examiner Assician and	dical Examiner	resulting in death)	Due to (or as a conse	quence of):	meer						2 months
O. Box 68	it the death certifical by the attending phy tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic p Other (s				:	23d. Date of deliv Month	rery Day Year
rds, P	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions cor Pulmonary embolism		sulting in the u	nderlying	cause given	in Part I.				the cause of death?
al Records,	The law ite has b	Completed	Or Managed to add to						1 ☐ Yes	psy ormed? 2 X No	prior to co	opsy findings available ompletion of cause of
on of Vital	ing Phy After this uneral d	tion: To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 □ Pending 2 □ Accident investigation	lospital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		Other: 28c. Injury a Work?	4 🗆 Nursin	g Home 5 Resi 28d. Describe	dence (fy)
Division	i Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	ify)				City or To	wn, State)	al Route Number,
	the Hospital in 24 hours a the Funeral I	edical	(Check only 2 Medicel Examinate)	sician: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or in	vestigation	n, in my opir	nion, death o	ace, and due to the courred at the time,	date and	place, and due t	o the cause(s)
	To the vithin 2.	M	29b. Signature and title of certifier	557-6	and the second		D 430				e signed (Month,	Day, Year)
E			30. Name and address of person who concerns a decision of the concerns and address of person who concerns a decision of the concerns and address of person who concerns a decision of the concerns and address of person who concerns a decision of the concerns and address of person who concerns a decision of the concerns and address of person who concerns a decision of the concerns and address of person who concerns a decision of the concerns and address of person who concerns a decision of the concerns and address of person who concerns a decision of the concerns and address of the concerns an		ical Ce		Dr.,	Rockv	ille, MD	2085	0	
	Sta Registi		FEB 25 200		5	10	m.Kal	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 0.01.

			1 - For State Registrar	State of Maryla	na / Depa <i>Cer</i>	tificate of	Death		erieZUUL	07601
ı	Physici	an	1. Decedent's Name (First, Middle, Last)	FANA	to			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give si	treet and number)		4b. City, Town, o	or Location of Dea	ath	4c. County of Deat	0415
Ī			WASHINGTON ADVENTI			TAKOMA			MONTGOMER	
1	Funeral Director		5/8 56 9484	M 2□F 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi	n. (Month, Day,	Year) 9. Birti Co WASH	nplace (State or Foreign untry) HINGTON DC
	ow .		Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	MARYLAND PRINCE G	EORGES	HYATTS	SVILLE				Yes 2☐No
	death with the Maryland ms 23a or 28a-f show roust be notified at	Directo	10e. Street and Number 5805 42nd Avenue			10f. Zip Code	781	10	g. Citizen of What Co	untry?
	Jeath Tis 23	Funeral		2. Was Decedent Ever in	U.S. 13. V			Specify Yes or No-	USA 14. Race - Ame	rican Indian,
030	thin 72 hours after death with the Marylan e. an "natural", or Items 23a or 28a-1 ahow Madical Examiner must be natified at	þ	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 ᅑ Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	-	fYes, specify Cub I□Yes 2ŽÎNo		(Specify Yes or No- erto Rican, etc.)	Black, White	o, etc. Black
ر ک	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	tent's Usual Occup kind of work done OO NOT use retire	pation during most of w	orking	6b. Kind of Business/I	ndustry
9500-61212	within 72 ene. than na	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire Fruck Dri			Priva	ite
	be filed wil tal Hygien d other th	Be Co	17. Father's Name (First, Middle, Last)					ame (First, Middle, M		
yland	should be and Mental marked c	To E	unknown				<u> </u>	de James		
, mar	2 e 7		19a. Informant's Name/Relationship (Typ Willie Taft Twyman/		4			Rumal Route Number, attsville,	City or Town, State, Z	
altimore,	ges 1 it of H if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Re 1 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other pla Ltan Cren			Oc. Location - City or 1	
Balti	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service License	nince to	nu 43	Name and Addres	ess of Facilit Ma: and Road	rshall's F d Suitland	uneral Hom , MD 2074	ne of MD
di			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	ath. Do not ente	er the mode of dyir	ng, such as cardi	ac or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	abyot	istic	,				Onset and Death
	/Medical Examiner			Due to (or as a conse	equence of):	C8 100	N			
H	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conse	equence of):	Vu				
•	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conse	QNUJ	arle	u d	iseas	2-6	
09/89	tificate be executed g physicien and as the burial-transit	edicai E	L d.							
	certifica ding pl	/Med	IF FEMALE:	c. If yes, outcome of pregr	nancy.					
C. Box	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnance Other (specify)	<i>y</i>		23d. Date of deli	very Day Year
ٽِ ت	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions cont	ributing to death but not re	sulting in the ur	nderlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ecords	equire sen sig ould b							1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Unknown
Lec C	The law r te has be bage 2 sh	ompieted						24a. Was an autopsy perform	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
Vital		e Co	25. Was case referred to medical				26 Place of De		No 1 □ Yes	2 No
	<u>></u> .∞ 0	ToB	evaminer?	ospital: 1 V Inpatient 2	☐ ER/Outpatien	t 3 DOA Ott	or	T-05-05-05	ce 6 Other (Spec	ify)
0 UC	50 00 00		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor	rk?	28d. Describe how	v injury occurred	
UNISION	or Attending P ifler death. Director: After t in by the funera	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre		Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
_	ie Hospitel or Attendin n 24 hours after death. te Funeral Director: Aft lietely filled in by the fur	ledical Ce	29a. Certifier Certifying Physi (Check only one) 2 Medical Examin	cian: To the best of my kr er: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the til	me, date and place	ce, and due to the car curred at the time, dai	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur Completely	Me	29b. Signature and title of certifier	and marmer states.		29c. Licens	e number	29	d. Date signed (Month	. Day, Year)
	E		Denn	ma (1)	nito	MD	6099	33	2/17/	04
-	(4)		30. Name and address of person who com	npleted cause of death (Ite			/ D-	Rockville	_ 11	2 A TO TOPOR
24	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	/300 nature	<u>iiccard</u> •	DR.	NOCKVITE	1/10, 2	0830
	Registr		CED 1 9 2004	Beach M.	Magali	9				

CPM 04-01158 Ronald Ford, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	f Maryland /	Depa <i>Cei</i>	artment of H tificate of L	ealth ai D <i>eath</i>	nd Men	tal Hygie Reg.	ne 2004	0760
	Physici	an	1. Decedent's Name (First, Middle,	.ast)						Date of Death Month	Day Yeer	3. Time of Death
	/Medic	_	Ronald Bland	Ford,					F€	bruary	11, 2004	16:24 M
	Examin	er	4a. Fecility Name (If not institution, g 6100 Wesson Dr		nber)		4b. City, Town, or Camp Sp				4c. County of Death Prince Geo	orge's
1	Funeral Director		577 08 6618	.Sex 1⊈M 2□F	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth Month, Day, Ye ril 7,	ar) 9. Birthp Coun 1970 Washi	ace (State or Foreign try) ngton DC
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	cation				11	Od. Inside City Limits
	Maryli f sho	ō	Maryland Prince	Coorgole		Clint						Tres 2 No
	the 728a-	Director	10e. Street and Number	George 3	, ,	<u> </u>	10f. Zip Code		-	10g.	Citizen of What Coun	try?
	h with	ai D	5541 Shallow Riv	er Road			20	735			USA	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f show aumatic event, the Madical Examiner must be neithed at	by Funerai	11. Marital Status 1 □ Never Married 2 Marned 3 □ Widowed 4 □ Divorced	Armed For	Mo e No	'	Vas Decedent of Hi f Yes, specify Cubai I ☐ Yes 2 ☐ K o	spanic Origi n, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race - America Black, White, e Specify: B1a	etc.
21215-0036	hour	ed t	15. Decedent's			a. Deced	lent's Usual Occupa	ition		16b	. Kind of Business/Inc	lustry
212	nin 72 In ne Medik	Completed	(Specify only highest (Secondary (0-12)			(Give life. I	kind of work done d DO NOT use retired,	luring most ()	of working			,
21	giene giene er tha	moC	12th	College (Driv	ver				Priva	te
Maryland	8 4 5 ×	To Be (17. Father's Name (First, Middle, La Ronald B. Ford,						's Name <i>(Fir</i> ah Pry	st, Middle, Maid O r	den Sumame)	
a _Z	es 1 and 2 should k of Health and Ment [Item 27 is marked r other traumatic e	-	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailin	g Address (Street a	and Number	or Rurai Ro	ute Number, Ci	ty or Town, State, Zip	Code)
	and 2 salth a n 27 Is		Cikeithia Ford/	wife				River		-	, Maryland	
ore	of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	☐Removal from 5	State cemet	өгу, сгөл	sition (Name of natory or other place		Date		. Location - City or To	wn, State
altimore,	Pages tment of I tant: If It		*4 □ Donation 5 □ Other (Spe	cify)	Harmo		femorial 1				ndover, Ma	
Ba	permit. Pages Department of Important: If I any injury or o		21. Sign was of Funeral Service Lid	sunce	-	43	308 Suitla	and Ro	oad Su	itland,	neral Home MD 20746	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cally one cause on ea	ach line			-		spiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediete Cause (Final disease or condition resulting in death)	a. M	ultiple	Juni	shit a	Joec	که ر			
3	Examiner			Due to (or as a consequence	d of):						
-		Jer	Sequentially list conditions, if any, leading to immediate nate Incardying Cause (Disease or injury	b. Due to (or as a consequence	e of):						
	cuted nd ransit	Examiner	that initiated events	c								
Ö,	cate be executed physician and the burial-transit	i Ex	resulting in death) Last	Due to (or as a consequence	e of):						
8760	cate b	dicai		d								
9 xo	eath certific attending p	a)	IF FEMALE:	23c. If ves. out	come of pregnancy						23d. Date of deliver	24
Bo	atten atten I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	↑ Live bi	irth 2 ☐ Fetal deat ant at time of death		Ectopic pregnancy Other (specify)					Day Year
P.O.	that the de ted by the a detached f	hysi	1 Yes 2 No 9 Unknown	9□ Unkno)WN							
Records, P	36 JE 90	by	Part II. Other significant conditions	contributing to de	eath but not resulting	in the ur	nderlying cause give	en in Part I.		23e. Did tobacc	co use contribute to the	1/
000	aw require s been sig 2 should b	Completed								24a. Was an	24b. Were autop	sy findings available
	The lav	mo.								autopsy performed 12 es 2	? death?	npletion of cause of 2□ No
Vital	ysician: Th	Be (25. Was case referred to medical examiner?					26. Place o	of Death (Ch	eck only one)	1	
	Physic this ce al dire	ဥ	1XYes 2☐ No				t 3 DOA Othe	4 LI NUIS		5 Residence		SCENE
nc	tanding Ph leath. tor: After th the funeral	ion	27. Manner of Death 1 □Natural 5 □ Pending		b, Day Year)	Time of Injury	Work	at ?? res 2 No		Describe how in	njury occurred	
Division of	or Attanding Physician: after death. Director: After this certific in by the funeral director,	Certification:	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	be 390 Place	of Injury - At home,	farm str	TAI	65 2 X		ocation (Street	and Number or Rural	Route Number
Ω	after Direct	ertii	4 Homicide determine	buildir	ng, etc. (Specify)		1		1	City or Town, St		ach Wessen
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1□ Certifying	Physician: To the	best of my knowledg	ge, death	occurred at the tim	e, date and	place, and o	due to the cause	e(s) and manner as sta	May/and
	he Ho in 24 he Fu pletely	edicai	one)	aminer: On the ba and mann	asis of examination a ner stated.	ind/or inv	estigation, in my op	oinion, death	occurred at	the time, date	and place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and little of certifier	., ,,	figo		29c. License				Date signed (Month, L	
^	(2)		1 Keoline		Somo			O.C.M.	.E.	Fe	bruary 12,	2004
_	(8)		30. Name and address of person when the state of the stat					opt. F	Raltim	ore Ma	ryland 212	Λ1
tje.	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Signature			CC, L	AAL LIHI	OLG, PIC	TATORY STS	OT
	Registr	_	CED 1 8 2004	Z. 1	Le d	T						

			1 - For State Registrar	of Maryland / Dep <i>Ce</i>							
ı	Physic	ian	1. Decedent's Name (First, Middle, Last)			2. Date of Month	_				
	/Medi		Lena Baumann Fuers			Feb.					
	Exami	ner	4a. Facility Name (If not institution, give street and r	-	4b. City, Town, or		4c. County of Death				
			Crofton Convalescent Convalesce		Croft		Anne Arundel				
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 K F	7. Age (In yrs. last birthday) 95 Yrs.	Months Days	Hours Min. 8. Date o	, Day, Year) Country)				
			Usual Residence of Decedent	93		July	5,1908 Germany				
	how		10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits				
	e Ma	cto	VA. James City	Willia	msburg		1 □ Yes 2 ¬No				
	ours after death with the Manylan ral', or Hems 23a or 28e-f show Examinar must be invitinal at	Dire	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?				
	s 23e	-B	117 Roger Smith		231		USA				
	er de Item	nue	Armed I	orces?	Was Decedent of His If Yes, specify Cuban	panic Origin? (Specify Yes o , Mexican, Puerto Rican, etc.	r No- 14. Race - American Indian, Black, White, etc.				
36	rs aft	by F	1 Never Married 2 Married 1 Yes, 0 3 XWidowed 4 Divorced Year or	2 1 No ive	1 ☐ Yes 2 ☑ No	Specify:	Specify: White				
21215-0036	in 72 hours n "natural", legical Exe	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupat	ion	16b. Kind of Business/Industry				
215	hin 7	ple	(Specify only highest grade completed Elementary/Secondary (0-12) College	(Give life.	kind of work done du DO NOT use retired)	uring most of working	,				
21	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or flems 23a or 28e-f show event, the Medical Exerting must be notified at	Completed by Funeral Director	Elementary/Secondary (0-12) College	Н	omemaker		Own home				
pu	d tal	Be	17. Father's Name (First, Middle, Last)	D		18. Mother's Name (First, Mic	·,				
yla	should be nd Mental marked o	2		Baumann		Madalena					
Maryland	C1 40 00 00		19a. Informant's Name/Relationship (Type, Print)				mber, City or Town, State, Zip Code)				
	1 and Health Iom 27		John Mayrhofer - Nephew 20a. Method of Disposition		Koger Smit	h, Williamsbu	rg, VA 23185 20c. Location - City or Town, State				
Baltimore,	m O		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from		natory or other place,						
量			* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Privide 15 15 15 15 15 15 15 1	Al 22	Name and Address	of Facility Beall F	Alexandria, VA.				
B	permit. Departrimports any injury		1000 700				wie, Md. 20715				
	* 5		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not ent	er the mode of dying,	such as cardiac or respirator	y arrest, Approximate				
	Physician		Immediate Cause (Final disease or condition								
	/Medical		resulting in death)	(or as a consequence of):	MACI	<u>Cherry 11 11</u>	a zys,				
7	Examiner		Sequentially list conditions b	renone	ral VCE	ocular I	Isease 5 VB.				
	pe tre	Examiner	cause. Enter Underlying	(or as a consequence of):							
_	and and I-tran	xarr	Cause (Disease or injury that initiated events resulting in death) Last	(or as a consequence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal E		(5. 45 4 55.1554551.55 51).							
9	ificate 3 phy: as the		d								
Box	eath certific attending p for use as	M/n		tcome of pregnancy			23d. Date of delivery				
m.	death e atte	icla	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year				
P.O.	res that the de signed by the a be detached f	Physiclan/Med	9 Unknown 9 Unki								
	res th igned be de	by	Part II. Other significant conditions contributing to	eath but not resulting in the ur	nderlying cause given	in Part I. 23e. D	id tobacco use contribute to the cause of death?				
ord	w require been si should I	ted	Dilloca	MRITTE	100	1	☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
Records,	has b	Completed	Valvular	HEGIT	Mear	24a. W	topsy prior to completion of cause of				
a F		S				1 ☐ Ye.	nformed? death? s 2 ☑ No 1 ☐ Yes 2 ☐ No				
Ž.	Physicien: The this certificate has al director, page	Be	25. Was case referred to medical examiner? 1. Type 2. Type 1. Type 2.		(v one)						
of	Phys r this ral dii	- To	1 Yes 2 No 1 28a. Date	Inpatient 2 ER/Outpatient of Injury 28b. Time of	t 3 DOA Other:	4 Nursing Home 5 Re	esidence 6 Other (Specify)				
on	ding Ith. After funer	thor		th, Day Year) Injury	Work?	s 2 No	e how injury occurred				
Division of Vital	I or Attending Physicien: after death. Director: After this certific i in by the funeral director.	fica	3 Suicide 6 Could not be determined 28e. Plac	of Injury - At home, farm, stre			(Street and Number or Rural Route Number,				
ā	9 # 12 E	Certification:	4 Homicide determined build	ing, etc. (Specify)	•	City or	Town, State)				
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier 1 Certifying Physician: To th	best of my knowledge, death	occurred at the time,	date and place, and due to the	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)				
	the h	Medi	and mar	ner stated.			e, date and place, and due to the cause(s)				
	With Con	4	29b. Signature and title of certifier	Mo	29c. License n	umber	29d. Date signed (Month, Day, Year)				
,	(5)		XII (WV)	1 110	15	2137	00/25/04				
/	(5/		30. Name and address of person who completed cau	se of death (Item 23a) (Type, F	ermill Bl	vd. Suite =	on fumbrile mb				
	Sta	te		egistrar's Signature	- 1111111111111111111111111111111111111	voc. suite	OWN WIND THA				
			ECD 9 5 200/								

		Registrar Certificate of Death Decedent's Name (First, Middle, Last)	Reg. No. 2. Date of Death Month Day Year	3. Time of Death
Physicia Medic/	_	Emma Marie Foote	FEB. 27, 2004	10:04А м
Examin		a. Fecility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL 4b. City, Town, or Location of Dea LAUREL	PRINCE G	EORGES
uneral irector		Social Security Number 6. Sex 1 Months	s. 8. Date of Birth (Month, Day, Year) Co. 03/06/1954 Prir	thplace (State or Foreign buntry) ace George!
nutified at	}	Jsual Residence of Decedent Oa. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
any injury or other traumatic event, the Mudical Examiner must be nutified at once.	ţŏ	MD Prince George's Laurel		1 ☐ Yes 2 No
2	Funeral Director	0e. Street and Number 10f. Zip Code	10g. Citizen of What Co	ountry?
	a D	8116 Goreman Avenue #202 20707	United Stat	es
	nner	1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.) 14. Race - Ame Black, Whit	
	by Fi	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No II Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:	Specify: B1	ack
	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business	/Industry
	Completed	(Specify only highest grade completed) (Give kind of work done during most of we life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)		
	S	7th Cook	Private	
	Be		me (First, Middle, Maiden Sumame)	
- 1	P	Clifton Foote Emma 19a. Informant's Name/Relationship (Type, Print) 219b, Mailing Address (Street and Number or, F	Thomas	Zin Code)
1		19a. Informant's Name/Relationship (Type, Print) Lynn Foote/ Daughter 19b. Mailing Address (Street and Number or F	202 Laurel, MD 2070	7
	10.	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or	
5			06/2004 Laurel, MD	
9	- 1		.B. Jenkins Funeral	
once		* K. D. Marsha (7474 Landover Road	Landover, MD 207	85
ian ical iner	ıer	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of): b. Due to or as a consequence of): Due to or as a consequence of):		Onset and Death
	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d		
	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of de Month	livery Day Year
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to 1 ☐ Yes 2 ☐ No 3 ☐ P	o the cause of death? robably 4 Dunknown
ממפי אוממים	Completed		24a. Was an autopsy performed?	utopsy findings available completion of cause of
tor, p	BeC	25. Was case referred to medical 26. Place of De	eath (Check only one)	
director,	10 E		Home 5 ☐ Residence 6 ☐ Other (Spe	cify)
		27. Manner of Death 1 ▼ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation 28. Injury at Work? 1 □ Yes ident investigation	28d. Describe how injury occurred	
TUNERA	0	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or R City or Town, State)	ural Route Number,
e E	ertific		J. Comments of the comments of	
£	dical Certification:	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	ce, and due to the cause(s) and manner a curred at the time, date and place, and due	s stated. to the cause(s)
completely filled in by the funera di	Medical Certific	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ	29d. Date signed (Monitorial)	e to the cause(s)

		1	For State Registrar	State of Maryla		artmer rtificat					Reg. No.	200		1605	
	Physicia	_	1. Decedent's Name (First, Middle, Las							Date of Dea Month	Day		3. Time	of Death	
1	/Medic	al	Alice Marga			45 65.	Tour	Location of		eb. 2		2004 County of Dea	9:44	Α	
	Examin	er	4a. Fecility Name (If not institution, give Carroll Hospin			1	,	nster			40.	Carro			
	Euporol		5. Social Security Number 6. Se	7. Age (In yrs	s. last birthday)	If Unde	r 1 Year	If Under 24	4 Hrs. 8	Date of Birt	h Voorl	9. Bir	thplace (State	or Foreign	
	Funeral Director		217-26-8128	□M 2XF 7	2 Yrs.	Months	Days	Hours	Min. 7 /	(Month, Da 09/3	1 1	Balt	imore	, MD	
	pu ,		Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Lo	ocation							10d. Inside (City Limits	
	shov	à	MD Carro				. 20							s 2 No	
	the N	ect	10e. Street and Number	JII	Westmi	10f. Zir					10g. Citi:	zen of What C	ountry?		
	3a or	<u>a</u>	26 Sullivan Ro	oad				157			ī	J.S.A.			
	filed within 72 hours after death with the Maryland hyglene. ther than *natural', or flems 23a or 28a-f show that the Madical Examinar must be molified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Dece		spanic Origin, Mexican,	n? (Specify	Yes or No		14. Race - Am Black, Whi	erican Indian,		
ဖွ	after or Ite	큔	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes		Specify:	. 40110 7 110	,,	1	Specify: Wh			
21215-0036	ural',	d by	3 Widowed 4 □ Divorced	Year or Dates:											
<u>7</u>	n 72 h	ete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	dent's Usu kind of wo DO NOT u	al Occupa ork done d ise retired	ition Ju <i>ring m</i> ost ()	of working		160. KII	nd of Business	vindustry		
12	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		nemak				:	Hor	nemaki	na		
	filed Hygi other		17. Father's Name (First, Middle, Last)					18. Mother	s Name (F	irst, Middle,			9		
an	lid be lental ked c	To Be	Arthur Joe S	Stritch				Ger	trud	le Ma	e Ni	iser			
Maryland	shou and M mar umat	-	19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Maili	ng Addres	s (Street a	ind Number	or Rural R	oute Numbe	er, City of	r Town, State,	Zip Code)		
	and 2 ialth a 127 is or tra		Margaret E. (ughter			lliva				ninste		2115	
ore	of He of He f Itam r oth		20a. Method of Disposition	Pemoval from State	. Place of Dispo cemetery, cre.	matory or	other place		Date			cation - City or			
Ĕ	Pag ment ant: I ury o		1 ☐ Burial 2 反 Cremation 3 ☐ * 4 ☐ Donation 5 ☐ Other (Specify	() C	arroll		V		/23/	04	Hami	stead	, MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be indiffied at ance.		21. Signature of Funeral Service Licen	SOO MO	1101 M	2. Name a	nd Addres	s of Facility	w Fu	nera	1 не	me. P	. A.		
	20 <u>5</u> € 0		Part Enter the disease, or comp	FIO	9	1 Wi	llis	str	eet	West	mins	ter,	MD 21	157	
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	b. Due to (or as a const	equence of):								Interval B Onset and	Death	
68760,	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a const., d	equence of):										
P.O. Box 6	the death certifica / the attending ph ched for use as th	ysiclan/Me	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	⊒Ectopic p ⊒ Other <i>(s</i>					2	23d. Date of de Month	elivery Day	Year
	w requires that the sbeen signed by the should be detache	by	Part II. Other significant conditions of	ontributing to death but not r	resulting in the t	underlying	cause give	en in Part I.			obacco u Yes 2[ise contribute i □ No 3 □ F	_	death? Unknown	
Vital Records,	e law has b je 2 st	Completed						· · · · · · · · · · · · · · · · · · ·				prior to death?	utopsy finding completion of s 2 No	s available cause of	
ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?						of Death (C	Check only o	one)				
	ng Phys tter this ineral di	은	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yeer)	Outpatie 28b. Time (Injury		28c. Injun Work	4 1401	280	5 Resi	_	6 Other (Sp.	ecify)		
Division of	To the Hospital or Attending within 24 hours after death.) To the Funeral Director: Atte completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		t home, farm, st ecify)	treet, facto				Location (. City or To		d Number or F	Rural Route Nu	ımber,	
	e Hospita 24 hours e Funeral letely fille	edical C		nysician: To the best of my kinner: On the basis of examand manner stated.										o(s)	
	withir. To th comp	Me	29b. Signature and title of certifier	0 ^		29	c. License	e number			29d. Dat	te signed (Mor	nth, Dey, Year)		
			> 11 Nt 12 1hr	why			Doo	5192	4	C	Febru	uni 2:	2,200	94	
	Cer		30. Name and address of person who	completed cause of death (I	tem 23a) (Type	, Print)		, , ,			- 1/.	e Mo			
	7		Herbert P. Hende	rson Jr. MD	2973	Mano	: Hes	ler P	LIN	lanch	e510	· Mo	2116	22	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sig											

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ORIGINAL

		_ For	State of		d / Depa	artmen	of H	ealth a	and M	lental Hyg	iene .		076	0.6
		Stete Registrar	(ant)		Cei	rtificate	e of L	Death		2. Date of Deat		2004	0 / 6	-
Physici		Month TIOND TRON CRORCE SR										Day Year 9:35 A		
/Medio Examir		4a. Facility Name (If not institution	give street and nu	mber)		4b. City,	Town, or	Location of	of Death	202		ounty of Dear		ALL
		Genesis Elder				If Under		ston If Under	24 Hrs.	8 Date of Righ		Tal	bot hplace (State or F	Foreign
Funeral Director		5. Social Security Number 212-12-3341	6.Sex 126 M 2□F	7. Age <i>(In yr</i> s. 81	Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month Day, NOV 8	922	MAR	YLAND	oreign
		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City I	Limits
Marylan f show	o		OM.	100.01									1 TXYes 2	
h the l	Director	MD TALB 10e. Street and Number	01		EAST	10f. Zip	Code			1	0g. Citize	en of What Co	ountry?	
ath wit	ralD	29443 DUTCHMAN						2160				USA		
ter dea Items irer o	Funeral	11. Marital Status 1 ☐ Never Married	Armed Fo		.S. 13.	Was Deced	ent of Hi	spanic Ori n, Mexicar	igin? (Spa n, Puerto	ecify Yes or No- Rican, etc.)	14	4. Race - Ame Black, Whit		
ours at	by	3 Widowed 4 Divorced	ed 1 □Yes If Yes, Gi Year or D	ve Ax Dates:		1□ Yes 2	X No	Specify:			5	Specify: W	HITE	
netui	Completed	15. Decedent (Specify only highes	's Education t grade completed)		(Give	dent's Usua kind of wor	k done d	uring mos	t of work	ing	16b. Kin	d of Business	Industry	
withir iene.	duo	Elementary/Secondary (0-12)	College (1-4or 5+)	MEAT PROCESSOR FO							FOOD		
In y latiful 2 12 13 15 15 15 15 15 15 15 15 15 15 15 15 15	BeC	17. Father's Name (First, Middle,	Last)						er's Name	e (First, Middle, M	Maiden S			
	10	JULIUS J. GEO			10h Mailis	- Addross	/Stroot o			BIGER	Cityon	Toum State	Zin Coda)	
i, Ivial yio and 2 should ealth and Mer n 27 is marke her treumatic		19a. Informant's Name/Relationsl BETTY F. GEORG			1	43 DF							.ip C008)	
D		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation			Place of Dispo cometery, crea	sition (Nan	e of	I .		EASTON Date	20c. Loc	ation - City or	Town, State	
Pages Iment of the tent: If its		`4 □Donation 5 □ Other (S)	pecify)		ING HI					3-2004	EAST	ON, MA	RYLAND	
permit. Pages 1 Department of the Importent: If its any injury or ot once.		21. Signature of Funeral Service	Licensee Asiali C.	ESP	F	2. Name an	S. H	ELFE	NBEI	& NEWN	AM F	UNERAL	HOME PA	
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	th. Do not ent	er the mod	HAK e of dying	RISOI g, such as	cardiac (EASTON, or respiratory arre	MD est,	21601	Approximate Interval Betwe	en
Physician		Immediate Cause (Final disease or condition	a 14	NWX.	A								Onset and Dea	ath
/Medical Examiner		resulting in death) Due to (of the a consequence of):												
	Je.	Sequentially list conditions, 13 y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. CerebbarAscul w Accoloute c. CerebbarAscul w Accoloute												
nd ransit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events				dre	ACC	de	-ki				· · · · · · · · · · · · · · · · · · ·	
be exesician a	cal Ex	resulting in death) Last	l	(or as a consec	quence at);									
do difficate g phys			d											
INISION OF VICE INCCOLUS, F.O. BOX 00/00, for the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. For the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live 4 ☐ Preg	itcome of pregn birth 2 □ Feta nant at time of c	aldeath 3	∃Ectopic pr ∃ Other <i>(sp</i>					23	3d. Date of de Month	ivery Day Yea	ar
at the d by the etache	Phys	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions									e contribute to	the cause of dea	ath?	
w requires the been signed should be d	ρ	D. Abetes									obably 4 Dunk			
aw req	Completed									24a. Was a autops		24b. Were au	utopsy findings ava	allable
The I	Com									perforr 1 ☐ Yes 2	ned?	death?	2□ No	
VIICA sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	TER/Outpaties	nt 3 DC	Othe			n <i>(Check only on</i> me 5□ Reside		Other (Coe	aih i)	
g Phy er this	n; To	27. Manner of Death	28a. Date		28b. Time o	_	8c. Injury Work	at	arsing Ho	28d. Describe ho			Chy)	
Attending Physic death. Sector: After this by the funeral	catlo	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	gation			М	10	/es 2□	-	TO(
or Att after d Direct	Certification;	4 Homicide determ	ined 288. Plac	e of Injury - At h ling, etc. <i>(Speci</i>		reet, factory	, office			City or Town	reet and 1, State)	Number or Hi	ural Route Numbe	ır,
To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate hat completely filled in by the funeral director, page	Medical C		g Physicien: To th Examiner: On the l and mai											
To th Withir To th comp	Me	29b. Signature and title of certifie	2 -			290	. License	number	./	2	9d. Date	signed (Mont	h, Day, Year)	
		30. Name and address of person	/ Let	use of death (la-	DO.	Print\	44	1818	5	7	L-	14-5	004	
		BAte; CK	Ster	-ling	508	F	dlen	rild	Ave	EAST	m	M	21601	
St Regist	ate	31. Date filed (Month, Day, Year)	004	Registrar's Sign	ature									
	rar 2001	202	A CONTRACTOR	a D.	Sal	S.o.								

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ORIGINAL

			- For	Indelible Ink. Ensure appartment of Health and Sertificate of Death	Mental Hyg	_						
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Emory McClure Garrett		2. Date of Deat Month FEBRAUR	h Day Year Y 20 2004 03:23 a M						
*	Examir Funeral Director		4a. Facility Name (If not institution, give street and number) St. Mary's Hospital 5. Social Security Number 5.78-22-1740 6. Sex 1 ☑ M 2 ☐ F 81 Yr	Months Days Hours Mir	s. 8. Date of Birth	Year) Country)						
	D	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location r d t own	journally 1	10d. Inside City Limits 1 □ Yes 2 No						
	ath with the 23s or 28	Funeral Director	10e. Street and Number 22300 Gore Street	10f. Zip Code 20650		0g. Citizen of What Country? USA						
920	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23a or 28e-f show he Madical Examiner mast be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes, 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 X No Specify:	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White						
21215-0036	in 72 ho n natur	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Rive kind of work done during most of w fe. DO NOT use retired)	orking	16b. Kind of Business/Industry						
	filed with Hygiene. other ther	Be Com	Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last)	Cable Splicer 18. Mother's No.	ame (First, Middle, M	Telephone Company						
Maryland	2 should be and Menta! Is marked o	To E	Eldridge McClure Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Name/Relationship (Type, Print)		Strausbury , City or Town, State, Zip Code)							
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Department of Heatih and Mental Hygiene Importent: If item 27 is marked other than "naturel", or iteme 23a or 28e-f show amy nitury or other treumatic event, the Medical Examiner must be notified at once.		20a Method of Disposition 20b. Place of D	98 Hopton Lane Lec	Date	MD 20650 20c. Location - City or Town, State						
Baltimore,			1 □ Burial 2 □ Cremation 3 □ Hemoval from State '4 □ Donation 5 □ Other (Specify) Charles	Memorial Gardens	2/23/2004 Leonardtown, MD							
Bal			Fight Cimens P.O. Box 270 Leonardtown, MD 20650									
60,	Physician /Medical Examiner portion and prize pr	al Examiner	23a. Part1. Inter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as	e of Lover		est, Approximate Interval Between Onset and Death						
O. Box 687	that the death certificate bed by the attending physic detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year						
ds, P.	es us	b	Part II. Other significant conditions contributing to death but not resulting in the form of the standard flower	ne underlying cause given in Parti.	23e. Did tot	pacco use contribute to the cause of death? es 2 10 3 Probably 4 Unknown						
Records,	elaw hasb je 2 sl	ompieted	Chrone ford was	efficiency	24a. Was a autops perform	prior to completion of cause of death?						
f Vital	ysicien: is certific director,	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outp	Othor	eath (Check only on							
Division of	or Attending ifter death. Director: After in by the fune	Certification;	27. Manner of Death 1	yry Work? M 1 ☐ Yes 2 ☐ No		reet and Number or Rural Route Number, n, State)						
	Ho: 24 h Fur etely	Medicai C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, and manner stated.									
	To the within 2 To the complet	Me	29b. Signature and title of certifier Fullule	29c. License number	198 2	9d. Date signed (Month, Day, Year)						
	JAN)		30. Name and address of person who completed cause of death (Item 23a) (TDAVID FEDERLE SHAH ASSOC PHILIP J		HOLLYWOOD	MD 20636						
No.	St Regist	ate	31. Date filed (Month, PEB 2 3 2004 32. Registrar's Signature	Sands.								

DHMH 17 Rev 1/2001

EMORY MCCLURE GARRETT

		,	For State Registrar	State of Ma	aryland		ırtmen tificate			nd M		giene Neg. No. 20	04	07608	
	Physici	an	1. Decedent's Name (First, Middle, I Amelia	Gree	n				Month	2. Date of Death 3. Time of Death					
	/Medic Examin		4a. Facility Name (If not institution, g	give street and number)		GECC	4b. City,		Location o	f Death	1 CDI uu	4c. County	of Death	10.00 h	
			12320 Catalina 5. Social Security Number 6		e (In yrs. las	et hirthday)	If Under	usby	If Under 2	4 Hrs.	8. Date of Birth	Calv		ace (State or Foreign	
	Funeral Director		207 16 9184		79	Yrs.	Months	Days	Hours	Min.	Month, Day	r, Year)	Coun	Virginia	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				rarract y			Od. Inside City Limits	
	Maryl a-f aho	ρį	Maryland Calvert	:	Lusk	ру								1 ☐ Yes 2% No	
	with the a or 28	Dire	10e. Street and Number 12320 Catalina	Drive			10f. Zip	^{Code} .					og. Citizen of What Country? United States		
	death ma 23	neral	11. Marital Status	12. Was Decedent 8	Ever in U.S.	. 13. \	Vas Deced	ent of His	spanic Orig	jin? (Spe	cify Yes or No-	14. Race	- Americ	an Indian,	
920	within 72 hours after death with the Maryland ene. than "natural", or itama 23a or 28a-i ahow Is Madlesi Evarrirar musi be naiffied at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🐼 N If Yes, Give Year or Dates:	No		r Yes, spec	•	Specify:	, Pueno r	Rican, etc.)		white,		
21215-0036	"natur	Completed	15. Decedent's (Specify only highest)			16a. Deced	lent's Usua kind of wor OO NOT us	k done di	urina most	of working	g	16b. Kind of Bu	siness/Inc	dustry	
2121	yithih jiene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5	F	'edera						accounti	ing c	elerk	
land	uld be filed fental Hyg rkad othe tic event,	To Be C	17. Father's Name (First, Middle, La Harry	st) Hudson				E	18. Mother Heler		(First, Middle,	Maiden Sumame Edv	vards	3	
Maryland	nd 2 shoulth and M 27 Is mai		19a. Informant's Name/Relationship Cherie Mae Ritch		er 2		-					r, City or Town, S urnie MI			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itama 23a or 28a-1 ahow any injury or other traumatic event, the Madical Examinating the notified at once.	Cherie Mae Ritchie- daughter 236 Apt. C Woodhill Dr. Glen Burnie MD 2 20a. Method of Disposition 1													
Balti	permit. I Departm Importal any inju		21. Signature of Euneral Service Lic			22	. Name an	d Address	s of Facility	, Rausc	h Fune	ral Home	PA	0.586	
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	omplications that caused ally one cause on each lin	ne.	Do not ente	er the mode	e of dying	, such as o	RO . cardiac or	POPE Re respiratory arr	epublic est,	MD 2	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as			·	 -							
	ted nsit	Examiner	Socientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
8760,	ate be executed hysician and the burial-transit	ical	d												
P.O. Box 68	Attanding Physician: The law requires that the death certifics reath. r death. sctor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 monthe? 1 □ Yes 2 □ 16 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	eath 3□	Ectopic pro				d	23d. Date Mon		ry Day Year	
	uires that t signed by ild be deta	b	LITAL CASE HAVE A CONTROLLING TO CONTROLLING THE CHOCKING OF T						n in Part I.		23e. Did to	tobacco use contribute to the cause of death? Ses 2 \(\subseteq \text{No} \) 3 \(\subseteq \text{Probably} \) 4 \(\subseteq \text{Unknown} \)			
Records,	ne law requir has been si ge 2 shoufd l	Completed	,								24a. Was an autopsy findings available prior to completion of cause of death?				
Ita	ian: Ti rificate tor, pa	Be Co	25. Was case referred to medical	11:	26. Place of Death					of Death	1 ☐ Yes (Check only or		□Yes	2 □ No	
) (hysic this ce al direc	은	examiner?	Hospital: 1 ☐ Inpatie		R/Outpatien		A Othe	r: 4 🗆 Nur			ence 6 □Othe)	
ion	ath. r: After ne funer	atlon	27. Manner of Death 1 ■ Natural 5 □ Pending 2 □ Accident investigat	28a. Date of Injui (Month, Day		8b. Time of Injury	М 2	Bc. Injury Work 1 □ Y	at ? es 2 □ N		ad. Describe n	ow injury occurre	d		
Division of Vital	al or Atta s after de al Diracto ed in by th	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be One Bless of Injury. At home form street feeters office						2	8f. Location (S City or Tow	treet and Numbe n, State)	r or Rurai	Route Number,	
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of taminer: On the basis of and manner sta	f examinatio	edge, death on and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	place, a	nd due to the c d at the time, d	ause(s) and mar ate and place, a	ner as stand due to	ated. the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier					License			2	9d. Date signed			
			30. Name and address of person wh	no completed cause of d	eath (Item 2	3a) (Type		136	,969			Feb. 19	, 20	···	
	15		Scaria Mat	hew. M.D. 1	11910	H.G.	Truen	nan R	d. Lu	ısby,	MD 200	657			
	Sta Registi	ite ar	31. Date filed (Month, Day, Year)	2 3 2004	ars Signatu	re K	doe	de s							

Usual Residence of Decedent 10s. State 10s. County 10s. City, Town or Location 10s. State 10s. County 10s. State 10s. S			For	State of Ma	ryland / Do	Indelible Ink.	lealth and M	-	iene		
HARVEY SYLVESTER GLADMON 4. Receive yours price extension, gots areas and members 4. Receive yours price extension, gots areas and members 5. Secul Secul Pulmers 6. Secul Secul Pulmers 7.				R PHY CCHD 2	2/26/04 DB (sertificate of	Death				
24 Point years of the restriction one store and number? CLY Is ta Medical Center La Plata La Plata La Plata La Plata La Control	Physici	an		CT A DMONT				Month	Day Ye	ear	
Civi sta Medical Cal Center Consider Number of Description (Proc. Modes) 100 States 100 Country 100 States 100 State						Ab City Town o	r Location of Death	Feb.			
Some Security Number Some Security Number Some Security	Examin	er			r						
ST7-22-5322 Wall Section State Section Section State Section State Section State Section Sec	uneral		5. Social Security Number 6. Sex	7. Age		day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	0	Birthplece (State or Forei	
Too State Too County Too County Too County Too County Too County Too State and Number Too State an	irector		577-22-5322	M 2 F	80 Yr	s. Months Days	Hours Min.	July 8 1	.923 Wa	shington, D	
23a	how				•					10d. Inside City Limi	
23a	29-fs	cto	Maryland Charles		Waldor	f. 				1 X Yes 2 ☐ I	
23a	or 28	Dire					•	10		t Country?	
23a	s 23a	rai									
23a	Item Tier	-nu		Armed Forces?	ver in U.S.	If Yes, specify Cuba	ispanic Origin? (Spi an, Mexican, Puerto	Rican, etc.)			
23a	P. O.	Ď	**	If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:		Specify:	White	
23a	heal	ted			16a. D	ecedent's Usual Occup	ation	ing	16b. Kind of Busin	ess/Industry	
23a	r than "	omple	Elementary/Secondary (0-12)		, ,	ife. DO NOT use retired	dannig most di work	_	bood		
23a	Vent,	3e C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N	faiden Sumame)		
23a	arke atic	2	Harry S. Gladmon				Annie Ru	bin Glad	lmon		
23a	re m									te, Zip Code)	
23a	m 27 her t			ladmon (W		Account to the second s					
23a	ant: If ite		1 Durin 2 Cremation 3 Re	emoval from State							
23a	Import any inj once.		21. Signature of Ameral Service License	M001	73						
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown 2 Unknown 2 Unknown 2 Year 2 Yes 2 No 9 Unknown 2 Year 2 Yes 2 Yes 3 Probably 4 Pregnant at time of death 5 Other (specify) 2 Yes 2 No 3 Probably 4 Unknown 2 Year 2 Yes 2 Yes 3 Probably 4 Unknown 2 Yes 2	/sician ledical aminer	_	Impediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of)	hui a				Onset and Death	
24a. Was an autopsy prior to completion of cause death? 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Was case referred to medical examiner? 1 Yes 2 No 28. Date of Injury M 1 Yes 2 No 28. Date of Injury M 1 Yes 2 No 28. Date of Injury M 1 Yes 2 No 28. Date of Injury M 1 Yes 2 No 28. Date of Injury M 1 Yes 2 No 29. Certifier (Check only one) 29. Certifier (Check only one) 29. Signature and title of certifier 29. License number 20. Place of Death (Check only one) 24. Was an autopsy findings availa prior to completion of cause death? 1 Yes 2 No 24. Was an autopsy findings availa prior to completion of cause death? 1 Yes 2 No 24. Was an autopsy findings availa prior to completion of cause death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death (Specify) 28. Date of Injury M 1 Yes 2 No 28. Date of Injury M 1 Yes 2 No 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	use as	hysician/Medica	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq 12 \) Yes 2 \(\subseteq 10 \) No	1☐Live birth 2 4☐Pregnant at ti	Fetal death					,	
The state of the s	an signed b		Part II. Other significant conditions cont	ributing to death but	not resulting in the	ne underlying cause give	an in Part I.	11.			
25. Was case referred to medical examiner? 1	ate has ber page 2 sho	omplet						autopsy perform	ed? prior deat	to completion of cause on?	
Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21 D-0060456	certifica rector. I	Be	examiner?	ospital:	-0	Othi	20	(Check only one)		
(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21 D-0060456	r: After this e funeral d	ation; To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury	28b. Tim	ne of 28c. Injury	at ?			Specify)	
Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21 D-0060456	el Directo	Certifica	determined 206. Flace of Injury. At Home, farm, street, factory, office 201. Location							(Street and Number or Rural Route Number, own, State)	
D-0060456 2/20/04	e Furer	dical ((Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
D-0060456 2/20/04	To th	Me	29b. Signature and title of certifier	1	1	29c. License	number	29	d. Date signed (M	onth, Day, Year)	
			January Ship D-0060456 2/23							0/04/	

		1 - For State Registrar	State of Maryla	and / Depa <i>Cei</i>	artment of <i>rtificate c</i>	Health and for the second seco	Mental Hy	/giene Reg. No.	2004	07610
-		1. Decedent's Name (First, Middle, Las	t)			-	2. Date of De	Day	Year	3. Time of Death
Physic /Medi		Glondola Beatri	ce Glenn				Febru	ary 1	5 , 2004	8:30 A M
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of Deat	th	4c. C	ounty of Death	
		Reeders Memorial	Home			onsboro			Washi	ington
Funeral		Social Security Number 6. Security Number		rs. last birthday)	If Under 1 Ye Months Day	ar If Under 24 Hrs		rth ay, Year)	9. Birth Cou	place (State or Foreign intry)
Director		212-24-3006	□ M 2UXF 75	7rs.			March	3,192	8 Ma	aryland
pug *		Usual Residence of Decedent 10a. State 10b. County	100.	City, Town or Lo	cation					10d. Inside City Limits
death with the Maryland ime 23a or 28e-f show r must be notified at	ō									1 □ Yes 2 No
88	Director	Maryland Washi	ngton	S	harpsbu			10- 0'1-		
De L	늅		D 1					iug. Citize	n of What Cou	intry ?
6 23	erai	3144 Harpers Fer	Y KOAD 12. Was Decedent Ever in	11.5		21782	Sacific Vac as N	- 14	USA . Race - Ameri	inon Indian
Item	ü	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 Yes 2 No	10.5.	If Yes, specify C	rf Hispanic Origin? (S uban, Mexican, Puer	to Rican, etc.)	J- 14	Black, White,	
P E	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 √)(1	lo Specify:		s	pecify:	1+0
neture Jical E	ed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Oc	cupation		16b. Kind	of Business/In	nite
- 5	pie	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work do: DO NOT use ret	cupation ne during most of wo ired)	rking			
른콥	Completed by Funeral	8	0011090 (1 401 04)		Secreta	rv		Exca	vating	& Well Dri
othe Vent.	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle			
rked tic e	TO E	James Franklin	Knight			Lottie	Mae M	yers		
and Mental Hygiene Is marked other the sumatic event, the	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Stre	et and Number or R	ural Route Numb	er, City or T	Γοwπ, State, Ziμ	o Code)
中には		James R. Glenn, Ji	Son	3144	Harpers	Ferry Ros	d Sharp	sbura	.Maryla	nd 21782
nt of Hea : If item or other		20a. Method of Disposition	200	D. Place of Dispo cemetery, crer	sition (Name of	nlace)	Date	20c. Loca	tion - City or T	own, State
ity o		1 ABurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Hemovariiom State	mples M		1	19,2004	Sharp	sburn M	lary Land
Importent: h any injury o		21. Signature of Funeral Service Lice	f hl			ress of Facility Uneral Ho	ome PA	o idi p	oo ar g i i	or y rand
lmpo any ir once	1	young Al	Ch	4	25 S. C	onococheag	THE ST W	illia	menort	MD 21795
		23a Part . Enter the disease, or comp shock, or heart ailure. List only	olications that caused the de	eath. Do not ent	er the mode of o	lying, such as cardia	c or respiratory a	rrest,	<u> </u>	Approximate Interval Between
sician		Immediate Cause (Final	2 Preym	1000						Onset and Death
ledical		disease or condition resulting in death)	a. Due to (or as a cons							2 well
aminer			conges	Five He	are 1	milure				year
	Je.	Sequentially list conditions, is a y, leading to in-rediate cause. Enter Underlying Cause (Disease or injury	Due to for an a cons	ecuance of)	, /					0
ransii	Examiner	that initiated events	· Alm	oscler	036					Jeans
an ag rial-t		resulting in death) Last	Due to (or as a cons	sequence of):				-		0
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astt		IF FF LAAL F						-		
endir r use	Physician/M	230. Was decedent pregnant	23c. If yes, outcome of pred 1 □ Live birth 2 □ F		Ectopic pregna	ncv		23	d. Date of delive	*
ne att ed fo	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)				Month	Day Year
by It	ķ	9 🗆 Unknown	am ouvilowii							
been signed by the attending physician and should be detached for use as the burial-transit	by	Part II. Other significant conditions of	entributing to death but not i	resulting in the ur	nderlying cause	given în Part I.				he cause of death?
en si ould l							1 🗆	Yes 2	No 3 ☐ Prob	bably 4 Unknown
s be 2 sho	Completed						24a. Was	an :	24b. Were auto	ppsy findings available impletion of cause of
ite has bage 2	Eo						perfo	ormed?	death?	2□ No
certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only			
this ce al direc	10	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3 DOA	Other: 4 Nursing H	łome 5 ☐ Resi	dence 6 [Other (Specif	(v)
r death. ector: Alier this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a		27. Manner of Death	28a. Date of Injury (Month, Day Year,	28b. Time of	28c. In		28d. Describe			
ath. r:Aft	atio	1 Natural 5 Pending 2 Accident investigation		, milaty		☐Yes 2☐No				
by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, offic	e	28f. Location (City or To	Street and f	Number or Rura	al Route Number,
ad in	Seri		building, old. (Spe	iony			Only of 70	in, claid)		
ly fill		29a. Certifier Certifying Phy (Check only 2 Medicel Exam	sician: To the best of my l	nowledge, death	occurred at the	time, date and place	, and due to the	cause(s) ar	nd manner as s	tated.
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	iner: On the basis of exam and manner stated.	mation and/or inv	vestigation, in m	y upinion, death occi	ured at the time,	date and pl	ace, and due to	o ine cause(s)
To t	Σ	29b. Signature and title of certifier	12			nse number		-	igned (Month,	
		1 1	1		DY	1996		res	16,2	1004.
1		30. Name and address of person who o	· ·							
		Dr. Zafar Halik	20311 Lappans	s Road,	Boonsbo	ro, Marvl	and 2171	3 / 3	01-432-	-8470
	ate	31. Date filed (Month, Day, Year)	32. Régistrar's Sig	nature	sell	~		• •		
Regist	202	ren 107	UU41 ACRESION	N. 14						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 200 L.

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John Robert Groves FEBRUARY 01:04 a.M 13, 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY Memorial Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03/14/1920 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1X M 2□ F Yrs. 83 Director 214-07-6831 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-f show other traumatic event, the Medical Examiner has be nutified at 1X Yes 2 No Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 618 Fairview Avenue 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1♥□Yes 2□No
If Yes. Give 1942 Year or Dates: 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1942**-**1943 1 ☐ Yes 2X No Specify 3. Widowed 4 □ Divorced "natural". White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ont: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 5 Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Alfred Groves Ruth 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If Item 27 Is any njury or other training once. 2523 E. Club Boulevard, Durham, NC Robert Groves / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State Sunset Memorial Park 02/21/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 13-1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exercises) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760 Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 Z No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours after To the Funeral Dire 4 | Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 IVA D0060478 FEBRUARY 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) Afaq Ahmad M.D. 625 Kent Avenue Cumberland, Maryland 21502 31. Date liled (Month, Day, Year) FEB 1 5 2004 32. Registrar's Signature State Registrar

			For State	State of Ma	aryland		irtment of H		ınd Mer		ene g. No. 20	nı.	ר ח	C 1 0
	Physici	an	Registrar 1. Decedent's Name (First, Middle, Last)	T7.	Б. С		incate of t	Jean	-	Date of Death Month	Day	Yeer	3. Time o	
100	/Medic	al	4a. Fecility Name (If not institution, give s	Virginia	F. G	odwin	4b. City, Town, or	Location o		ebruary	18, 20		4:15	A M
\$	Examin	er	Wilson Health Care				Gaither				Mont		ry	
	Funeral		Social Security Number 6. Sex		95	st birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birth (Month, Day,	Year)	9. Birthp Coun	lace (State	or Foreign
	Director		577-01-1165 Usual Residence of Decedent		93				νc	t. 28,	1908	Virg	ginia	
	ryland		10a. State 10b. County		10c. City,	Town or Lo	cation		-			11	0d. Inside C	•
	8a-f s	Director	Maryland Montgome	ry		Roc	kville							2 <u>1</u> No
	with ti	Dir	10e. Street and Number 6830 Old Stage Roa	nd.			10f. Žip Code	20852			g. Citizen of Wi United		•	
	death ma 23	Funerai		12. Was Decedent E	Ever in U.S	6. 13. V	Vas Decedent of H Yes, specify Cuba				14. Race	- Americ	en Indian,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural', or Items 23e or 28e-f show minory or other traumatic event, the Madical Examination of the results of the pages.	by Fur	1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	lo	1	Yes, specify Cuba	n, Mexican, Specify:	, Puerto Rica	an, etc.)	Specify:	White, o	etc. ite	
8	tural stural	ed b	15. Decedent's Educ	Year or Dates:		16a. Deced	ent's Usual Occupa	ation		11	6b. Kind of Bus			
215	thin 72 B. Bn "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	+)	(Give	kind of work done of OO NOT use retired	lurina most	of working				,	
2	ygien ygien yer tha	Con	12			Homen	naker				Own Ho			
Maryland 21215-0036	ntal H ed oth	Be	17. Father's Name (First, Middle, Last) James William Folt	. 7							aiden Sumame,	,		
2	should nd Me mark matic	၉	19a. Informant's Name/Relationship (Type			19b. Mailin	g Address (Street a		la Ale		City or Town, S	tate, Zip	Code)	
Ma	alth ar		Jane G. Tascher/Da	ughter			Old Stage							
ore,	or He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Pla	ace of Dispo	sition (Name of patory or other place e Presbyte	θ) .	Date Februa	ry 21	0c. Location - C	ity or To	wn, State	
altimore,	tment tant: I		* 4 ☐ Donation 5 ☐ Other (Specify)		Chu	rch Ce	metery		2004	G	ermanto			
Ba	permit Depar Impor any in		21. Signature of Funeral Service/License	e	M00	198 300	Name and Address bert A. West Mon	s of Facility Pumph Itgome	rey Fu	neral ., Rock	Home/Ro	ckvi MD 20	.11e, 0850-28	Inc. 05
F		İ	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each lin	the death.	Do not ente	er the mode of dying	g, such as o	cardiac or re	spiratory arres	st,		Approximat Interval Bet Onset and	tween
*	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	de	me	into	~						1ezr	5
100	Examiner			Due to (or as a	a conseque	ence of):							I	
	2	ner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying	Dua to (or as a	а полявания	ence of):								
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. =										
8760,	be executed sician and burial-transit	ai E	rosuling in osalin, East	Due to (or as a	a conseque	ence or):								
687	tificate I ig physi as the t	edicai	d	•										
Вох	death certificate be executed e attending physician and id for use as the burial-transit	an/M	23b. was decedent pregnant	3c. If yes, outcome of			Ectopic pregnancy				23d. Date		-	
о. П	the dea y the at ched fo	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at 9☐ Unknown			Other (specify)				Monti	1	Day	Year
S,	The law requires that the de Ite has been signed by the a vage 2 should be detached t	by Pt	Part II. Other significant conditions con	tributing to death bu	ıt not result	ting in the un	derlying cause give	n in Part I.		23e. Did toba	cco use contrib	ute to th	e cause of o	death?
ord	w require been sig								— <u>I</u>	1 🗆 Yes	2 □ No 3	Proba	ably 4 🔀	Onknown
Vital Record	e law i has b	Completed								24a. Was an autopsy performe	pri	ere autop or to com ath?	osy findings npletion of c	available cause of
ā		e Co	OF Man nano referred to modical							1 ☐ Yes 2			2□ No	
	Physician: this certifica	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	nt 2∏F	R/Outpatient	3 DOA Othe	_	72-12 TATE	5 □ Residen	ce 6 □Other	(Specify	.)	
Division of	ding Phy h. After thi funeral c	on: T	27. Mann of Death 1 Autural 5 Pending	28a. Date of Injur (Month, Day		28b. Time of Injury	28c. Injury Work	at ?	28d.		injury occurred		/	
ISIO	deat deat ctor: / the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ırv - At hor	ne. farm. stre		/es 2□N		Location (Stre	et and Number	or Rural	Route Nur	nher
2	or Tite	Certification:	4 Homicide determined	building, etc	. (Specify)		,			City or Town,				1007,
	To the Hospital Within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	examinatio	ledge, death on and/or inv	occurred at the timestigation, in my op	e, date and inion, death	place, and hoccurred a	due to the cau t the time, date	se(s) and manr e and place, an	er as sta d due to	ated. the cause(s	5)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	1 1 -			29c. License				f. Date signed (
	5		> 大儿	John.			D . 2	1014	8	F	ebruary	18	, 20	04
			30. Name and address of person who con Steven Dolo	mpleted cause of de	eath (Item 2	23a) (Type F		Ave	2.,6	authers	burg 1	nd	٨	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 23 200	32. Registra	ır's Signatu	JI J	Sparks	/						

State of Maryland / Department of Health and Mental Hygiene 2001 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 5:41 a M February 22, 2004 Henry Willard Goldin /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Nursing & Rehab. Center Kensington Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**ৣ**M 2□F Yrs. Director 086-01-0551 87 New York Apr. 7, 1916 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location ral', or iteme 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11533 February Circle, #201 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: White 3 Widowed 4 Divorced WWII "natural" the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 Salesman Retail 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil timent of Health and Menta! H tant; If item 27 is marked out 18. Mother's Name (First, Middle, Maiden Sumame) Be Isadore Goldin Sarah Kaplan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11533 February Circle #201, Silver Spring, MD 20904 Jean Goldin/ Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State injury or 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State February 24 permit. Page Department of Important: If any injury or ance. King David Memorial 2004 Falls Chu Francis J. Collins Funeral Home Inc. * 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, Virginia 21. Signature of Funeral Service Licensee mohen 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Duknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 Yes 2 Ro 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate rs after deam. Iral Director: After this cer... 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 2X No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 [] Homicide ō within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bao,40 20057124 2/23/04 3+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao M.D. 13219 Executive Park Terrace, Germantown, 10 20874 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2004 Registrar

			State	e of Maryland / Depa	artment of Health and Mertificate of Death	ental Hygien	
		_	Registrar	Cei		Reg. N 2. Date of Death	3. Time of Death
I	Physici /Medic		1. Decedent's Name (First, Middle, Last) Morris Goldner		F	Month D	Year 24, 2004 6:10 P M
	Examir		4a. Facility Name (If not institution, give street as	nd number)	4b. City, Town, or Location of Death	4	c. County of Death
			Casey House		Rockville		lontgomery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Yea	
	Director		051-28-7051	93 Yrs.	N	lov. 9, 19	10 New York
	pu ,		Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	aryla	5	Tod. State				1 ☐ Yes 2 🕱 No
	Ba-f	octo	Maryland Montgomery	Rockvill		100.0	Citizen of What Country?
	ith th	Dir	10e. Street and Number		10f. Zip Code		
	ath v	- a	14417 Pecan Drive	2	20853		14. Race - American Indian.
	tems	une	Am	Decedent Ever in U.S. ed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	lican, etc.)	Black, White, etc.
36	or l	γFi	_ If Ye	Yes 2 No es, Give	1 ☐ Yes 2 ☑ No Specify:		Specify:
00	ural'	q p		r or Dates:	dent's Usual Occupation	16b	White Kind of Business/Industry
21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or items 23e or 28e-f ehow he Madical Examirer must be nutified at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade compl	eted) (Give	kind of work done during most of workin DO NOT use retired)	g Tob.	Tallo of Dasiriosa modelly
2	withir and the state of the sta	Ę.		ege (1-4or 5+)		There	mituma Namufaatuman
	filed withi Hygiene. other than		17. Father's Name (First, Middle, Last)	Bus	sinessman 18. Mother's Name		niture Manufacturer en Sumame)
an a	2 should be filed withir and Mental Hygiene. Is marked other than eumatic avant, the M	Be			Celia G	roon	
7	should ind Men marke umatic	2	Joseph Goldner 19a, Informant's Name/Relationship (Type, Prin.	19h Maili	ng Address (Street and Number or Rural		or Town State Zin Code)
Maryland	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury prother treumatic avant, the Madical Examinist must be nutified at ance.		Barbara Brill-Daughte		Pecan Dr. Rockvil		
e,	permit. Peges 1 and 2 Department of Health a Important: If item 27 is any injury, prother tre		20a. Method of Disposition	20b. Place of Dispo	sition (Name of Da		Location - City or Town, State
Baltimore,	Ses = 20		tv⊡ Burial 2 ☐ Cremation 3 ☐ Removal	from State cemetery, cres	matory or other place)		
Ë	tant tury		Donation 5 ☐ Other (Specify)		Remembrance Feb. 2		
3ai	Deparition Departiment Important in Sun Sun Sun Sun Sun Sun Sun Sun Sun Su		21. Signature of Funeral Service Licensee		2. Name and Address of Facility Hin		
	00 F # 04		Law T. Ville				er Spring, MD 20904
			23a. Part1. Enter the disease, or complications thook, or heart failure. List only one caus	that caused the death. Do not ent e on each line.	er the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician			n-Small Cell Lur	g Cancer		2 Years
	/Medical Examiner		resulting in death)	ue to (or as a consequence of):			
н	Examiner		Sequentially list conditions. b				
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of):			
	and trans	ше	that initiated events c resulting in death) Last	us to (ar as a sonoguenes of):			
760,	e exi	<u> </u>	positing in douting Education	ue to (or as a consequence of):			
376	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the buriat-transit	lical	d				
.89	ing p	Physician/Medi	IF FEMALE:				
Вох	uth ce itend	an	23b. Was decedent pregnant		Ectopic pregnancy		23d. Date of delivery Month Day Year
.O.	a dea he at	SICI	1 Yes 2 No	Pregnant at time of death 5 [Unknown	Other (specify)	 	
P.0	at the	P. P.	9 Unknown		de la companya de Para (22a Did tobacco	use contribute to the cause of death?
	SE CE 00	þ	Part II. Other significant conditions contribution	g to death but not resulting in the u	nderlying cause given in Part I.		2 No 3 Probably 4 Unknown
Records,	w require been sign should b	ted				1 1 1 1 1 1 1	2 No 3 Probably 4 Control
000		pie				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ě	The law cate has to page 2 s	Completed				performed?	death? No 1 ☐ Yes 25 No
of Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
\	ysic is ce direc	To	1 ☐ Yes 2√2 No Hospital	1 Inpatient 2 ER/Outpatier	nt 3□ DOA Other: 4☑ Nursing Hom	e 5 Residence	6 ☐Other (Specify)
0	ig Ph ter th			Date of Injury (Month, Day Yeer) 28b. Time o	f 28c. Injury at 2 Work?	8d. Describe how in	jury occurred
0	Attending ir death. ector: After by the fune	atic	2 Accident investigation		M 1 Yes 2 No		
Division	er de recto by th	E S	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 2	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
Ö	s aft s aft et Dii ed in	Certification:					
	hour uner uner	cal			h occurred at the time, date and place, a vestigation, in my opinion, death occurre		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical		d manner stated.			
	To t To t	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month, Dey, Year)
	5		1962	\sim	D35635	Feb	. 25, 2004
			30. Name and address of person who complete	d cause of death (Item 23a) (Type,	Print)		
					l. Rockville, MD 20	855	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1		
	Regist	rar	FEB 26 2004	Janerea B	Sparks		

			For State Registrar	State o	of Maryland		artment rtificate			ind M		giene Reg. No.:	20	0 L	07615
	Physicia	212	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	Day		Year	3. Time of Death
	/Medic			1.	GOLDSTE	EIN	# 0" T				FEBRUAI				10:24 P M
	Examin	er	4a. Facility Name (If not institution, SUBURBAN HOSPIT		mber)		BETH		Location o	r Death			County of	GOMER	ov.
	Funeral			S. Sex	7. Age (In yrs. las	t birthday)	If Under 1	Year	If Under 2		8. Date of Bir (Month, Da		ONIC		lace (State or Foreign try)
	Director		579-18-3145	1 ∑ M 2□F	80	Yrs.	Months	Days	Hours	Min.	1.1/28/	1923			INGTON, DC
	pur &		Usuaf Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation							1	0d. Inside City Limits
	Maryle f eho	or	,	TEDV											1 ☐ Yes 2 🖺 No
	Jeath with the Marylan ms 23s or 28s-f show mark to notified at	Directo	MARYLAND MONTGOM 10e. Street and Number	EKY	CHEV	Y CHA	10f. Zip (Code				10g. Citiz	en of W	/hat Coun	try?
	h with		3400 PAULINE DRI	VE				208	15				U.S	.A.	
	ems :	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S. orces?	13.	Was Decede	ent of His fy Cubar	panic Orig	gin? (Spe , Puerto i	cify Yes or No Rican, etc.)	- 1	4. Race		an Indian, etc.
30	al', or Iter	by Fu	1 ☐ Never Married 2 🖾 Marrie 3 ☐ Widowed 4 ☐ Divorced		^{2□No} 1.948− ve Dates: 1.952−5	-49	1 ☐ Yes 2		Specify:				Specify:		
3	n 72 hours after death with the Maryland "natural", or liems 23a or 28a-f ehow calcal Examiner must be incitied at	ed b	15. Decedent's			16a. Dece	dent's Usual					16b. Kir	d of Bur	siness/Inc	WHITE
215-0036	within 72 iene. 'then "na the Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	life. I	kind of work DO NOT use	done di e retired)	uring most	of workir	ng				_
	D 0 =	Соп		5+		DENTI	ST						CIST		2
Maryland 21	0 = 0 >	Be	17. Father's Name (First, Middle, L.							r's Name	(First, Middle				
Ž	should nd Men marke umatic	ဥ	MORRIS G. GOLDST 19a. Informant's Name/Relationshi			19b. Mailir	na Address (ROSE	r or Rura	l Route Numb		Town. S		Code)
	and 2 sealth and 2 to 27 le		TRENICE GOLDSTEI								CHASE				
altimore,	Item of Head		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name	e of			ate				wn, Stete
Ē	Pages ment of ant: If its ury or o		1 ⊠ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Special Control C		State		-		1	2/20	/2004	CLAR	KSBI	URG,	MARYLAND
Balt	permit. Pages t and 2 should b Department of Health and Menta Important: If Item 27 ie marked any injury or other traumatic e ones.		21. Signature of Funeral Service L	. / Jui		DA	Name and NZANS	KY-C	EXPLOS	ERG 1	MEMORIA ROCKV	L CH	APEL MI	LS, I	NC. 852
۲			23a. Part I. Enter the disease, or c shock, or heart fallure. List o	omplications that only one cause on	caused the death.										Approximate Interval Between Onset and Death
8	Physician		fmmediate Cause (Final disease or condition resulting in death)	a. CARDI	AC ARRHY	THMIA								4	4 HOURS
8	/Medical Examiner		resulting in dealin)	Due to	(or as a consequer	nce of):									
- 2	д Э	ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequer	nce of):								_	
	cuted od ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
Ö,	ate be executed hysicien and the burial-transit	Ex	resulting in death) Last	Due to	(or as a consequer	nce of):									
8760	certificate be executed ding physicien and use as the burial-transit	dical		d											
Box 6	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnanc							2	3d. Date	of delive	ry
	ne death the atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 Fetal de nant at time of deat]Ectopic pre] Other (spe						Mont	th	Day Year
J O	at the	Phys	9 🗆 Unknown							-	I 5:11				
ecords,	The law requires that the death Ite has been signed by the atter page 2 should be detached for u	by	Part II. Other significant condition	s contributing to d	leath but not resulti	ng in the ui	nderlying ca	use give	n in Part I.			_	_		e cause of death? ably 4 XDUnknown
ဝင္ပ	law re as bed 2 sho	Completed									24a. Was	an	24b. W	ere autor	osy findings available inpletion of cause of
ĸ		Con									perfo 1 ☐ Yes	rmed?	de	eath?	2□ No
Vital	Physician: The law this certificate has ral director, page 2.3	Be	25. Was case referred to medical examiner?	Hospital:							(Check only o			-	
ō	Phy this rald	2	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date	of Injury 28	VOutpatien Bb. Time of	at 3□ DOA	lc. Injury Work			ne 5 🗆 Resi				9
ion	ttanding F death. tor: After the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		eth, Day Yeer)	Injury	М		? es 2 □ N	No					
Division	ire ire by	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 289. Place	e of Injury - At home ing, etc. (Specify)	e, farm, str	eet, factory,	office		2	28f. Location (City or To		Number	r or Rura	Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medicel E	xeminer: On the b	e best of my knowle easis of examination oner stated.	edge, death n and/or inv	n occurred a vestigation, i	I the time	e, date and inion, deat	d place, a	and due to the	cause(s) a	and man place, ar	ner as stand due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	05			29c.	License	number			29d. Date	signed	(Month, L	Day, Year)
	10		• pun	7	W		DO	0037	891		1	EBRU	ARY	18,	2004
	(30. Name and address of person w					Me	11.00	Do o					0050
	Sta	to-	AMIT RAJVANSHI, 31. Date filed (Month, Day, Year)		21 CONGRE					KOCI	CVILLE,	MAR	LAN	עו 2	0852
	Registr		FEB 24		Eperan	19	100	ch	/						

			1- State of Maryland / De Registrar		giene _{Reg. No.} 2004 076 L
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) Mazie E. Greenwald 4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington	2. Date of De Month Februar 4b. City, Town, or Location of Death Rockville	ath Day, 2004 3. Time of Death 5:15 A. M 4c. County of Deeth Montgomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 206–26–1639 1 M 2 F 92 Yrs.	Months Days Hours Min. (Month, Day 25,	1911 Pennsylvania
	be filed within 72 hours atter death with the Maryland tal hygiene. dother than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at	Funeral Director	Maryland Montgomery 10c. City, Town or Rockvi. 10e. Street and Number 6121 Montrose Road		10d. Inside City Limits 1 ☑ Yes 2 □ No 10g. Citizen of What Country? United States
900	nours atter death ural', or items 2	by		3. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ▼ No Specify:	- 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	filed within Hygiene. Ither than "	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired) nemaker 18. Mother's Name (First, Middle,	16b. Kind of Business/Industry OWN Home
arylan	should be and Mental s marked o	To Be	Charles Weissman		sman
	Pages 1 and 2 nent of Health a int: If item 27 la		20a. Method of Disposition 20b. Place of Dis	reentree Court, Bethesda, M. position (Name of remaior, or other place) Win University February 20	20c. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ment; Important: If item 27 is marked any injury or other traumatic e once.		Medical	Center 22. Name and Address of Facility Columbia Mortuary Service P.O. Box 58007 Washington	Washington, D.C.
	Pnysician:	. 15	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a.	enter the mode of dying, such as cardiac or respiratory and	rest, Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physicien and id for use as the burial transit	lical Examiner	Due to (or as a consequence of): 5a userie by the conflicion if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
P.O. Box 68		Physician/Med		B⊟Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the		bacco use contribute to the cause of death?
Vital Records,	The law ate has b page 2 s	Be Completed	25. Was case referred to medical	24a. Was autop autop perfici 1 ☐ Yes 26. Place of Death (Check only or	prior to completion of cause of death? 2 PNo 1 Yes 2 No
ō	Attending Physician: r death. ector: After this certific by the tuneral director,	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Mann of Death 1 Autural 5 Pending (Month, Day Year) 2 Accident investigation	ent 3 DOA Other: 4 Jursing Home 5 Resid	
DIVISION	1 1 te	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	City or Tow	
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the time, o	ause(s) and manner as stated. late and place, and due to the cause(s)
	2 min C oo	<	29b. Signature and title of certifier Hay & Willes M + D.	0225228	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type Gray B. Wilks, MD G (2) MCH	A Print)	MAYLAND ZOSSE
	Sta Registr	te ar	31. Date filed (Month, Day, Year) 32 Registrar's Signature 9	Spark	,

			1 - For State Registrar	State of Maryla	ınd / Depa		lealth and M	ental Hygiei	_
	Physici /Medi		1. Decedent's Name (First, Middle, Last Berta Juana Juno	o Grillo				February	Day Year 20, 2004 6:11 P
	Examir		4a. Fecility Name (If not institution, give Holy Cross Hospi			4b. City, Town, o	Spring		4c. County of Death Montgomery
	Funeral		Social Security Number 6. Se	x 7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreig
H	Director		579-48-4332 10 Sual Residence of Decedent	3M 2∏F 8	8 Yrs.	- Days	J. J.	une 23, 1	915 Cuba
	show ed al	-c	10a. State 10b. County		City, Town or Lo				10d. Inside City Limit 1 [XYes 2 □ N
	28a-1	rect	Maryland Montgome 10e. Street and Number	ry 51	lver Sp	10f. Zip Code		10g.	Citizen of What Country?
3	23a ol	a D	2201 Colston Driv	e #311		20910		υ	nited States
	be lied within 7 c hous after dean with the maryland tal Hygiene. Ital Hygiene. do other than "natural", or items 23a or 28a-f show event, the Maylicel Examitter main be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	i	Was Decedent of H f Yes, specify Cuba 1 XYes 2 ☐ No	ispanic Origin? (Spe in, Mexican, Puerto F Specify: Cub		14. Race - American Indian, Black, White, etc. Specify: Cuban
	onn 72 nou e. en "nature Medicel E	Completed	15. Decedent's Edul (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give		ation during most of workin f)	16b	. Kind of Business/Industry
	Hygiene. Hygiene. other than	Com		1	Cle	rk			.C. Government
	marked oth	To Be	17. Father's Name (First, Middle, Last) Miguel Junco				18. Mother's Name Rosa Jo		fen Sumame)
	and and is m		19a. Informant's Name/Relationship (T)		4.	-			y or Town, State, Zip Code)
•	other tr		Nelson J. Grillo,		4506 Place of Dispo		od Court,		
	nent of H		1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crer	natory or other plac	:e)		Location - City or Town, State
			 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligerts 			oln Cemet . Name and Addre			entwood, Maryland al Service
	Departr Departr Importa any infi		Superel Thom	1000 1					ington, D.C. 2001
	hysician /Medical Examiner		23a. Part. Enter the disease, or compishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. Acute My o	ocardia				Interval Between Onset and Death
	ysician and	Examiner	Sequentially list conditions. If any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a nonse					
1	physicials the but	dical		d. —					
100	ned by the attending phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year
	been signed by the should be detached	by	Part II. Other significant conditions con	ntributing to death but not re	esulting in the u	nderlying cause give	en in Part I,		o use contribute to the cause of death? 2 □ No 3 □ Probably 【 □ Unknow
-	ate has b	Completed						24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
100	this certificat	Be	25. Was case referred to medical examiner?	lospital:		Oth	26. Place of Death	(Check only one)	
	this ral dir	1: To	1 ☐ Yes 2 🚵 No	28a. Date of Injury	ZER/Outpatien		# Nursing Hom	e 5 Residence	6 □Other (Specify)
100000	after death. Director: After th in by the funeral	ertification:	1 ♠Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year) 28e. Place of Injury - At	Injury		Yes 2 No		and Number or Rural Route Number,
1		O	4 Homicide determined	building, etc. (Spec	cify)			City or Town, Sta	ate)
1	within 24 hours after To the Funeral Discompletely filled in	edicai	29a. Certifier 1 XCertifying Phy (Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the time restigation, in my op	ne, date and place, a pinion, death occurre	nd due to the cause d at the time, date a	r(s) and manner as stated. and place, and due to the cause(s)
-	within 2 To ths complet	X	29b. Signature and title of certifier	W		29c. License			Date signed (Month, Day, Year)
5			30. Name and address of person who co			Print)	4348		ebruary 20, 2004
			Steven Gruffenma				oad, Silve	r Spring,	MD.
	Sta Registi		31. Date filed (Month, Day, Year) FFR 2.4 200	32. Registrar's Sig	nature	Sparks	/		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician James Edward Griggs, Sr. **February** 18, 2004 8:50 A.M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. November 20, North Carolina 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F 577-42-7225 72 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event. It e Medical Examinar must be notified at Maryland Director Montgomery 1 X Yes 2 ☐ No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10940 Pebble Drive 20902 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry U.S. General Services al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Engineer Administration permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0scar Griggs Whaley Fannie 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Ann Harrison Griggs 10940 Pebble Drive; Silver Spring, Maryland 20902 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 21, 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signatuje of Funeral Service Licensee R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, DC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Metastatic Lung /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of). Examiner certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Munknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After Natural 5 Pending investigation Injury death. 1 Tyes 2 No within 24 hours after death To the Funeral Director: the 2 Accident 6 Could not be 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide illed 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical he 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Potel Jayanti 1) 052586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jayanti L. Patel, M.D.

Holy Choss Hospital Silver spring Maryland

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)"

	1 - For State Ragistrar	State of Maryland	I / Department of Health and Certificate of Death	Reg. N	0.
Physician /Medical	1. Decedent's Name (First, Middle, Last) Leroy Gilli	iam Sr.		2. Date of Death Month Date of Death Month Date of Death	415 2004 8-03AM
Examiner Funeral	4a. Facility Name (If not institution, give s Doctor Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. la	4b. City, Town, or Location of Dea Lanham st birthday) If Under 1 Year If Under 24 Hr Months Days Hours Mir	p.s. 8. Date of Birth	county of Death rince George 9. Birthplece (State or Foreign Country)
Director	237-30-2858 Usual Residence of Decedent	^{lm 2□F} 80	Yrs. Months Days Hours Min	Sept 24	1923 North Carol
Genth with the Maryland death with the Maryland times 23e or 28e-f show Errost be notified at meral Director	10a. State 10b. County DC		Town or Location hington		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the Mar 3a or 28a-f si if the modified	10e. Street and Number 314 Todd Place		10f. Zip Code 20002	10g. C US	itizen of What Country?
036 urs atter urs atter all; or the starting by Fur		12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	i. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 No Specify:	Specify Yes or No- irto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036 ed within 72 hours att ygiene. ner then "natural", or nt, the Medical Exami	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 10th		16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) Custodian Foreman	orking	Gind of Business/Industry Public School
Taryland 212. 2 should be filed within and Mental Hygiene. is marked other then summitte event, the M	17. Father's Name (First, Middle, Last) Jacob Gilliam		18. Mother's N	ame (First, Middle, Maide a Hyman	
Maryland d2 should be filt in and Mental Hy 27 is marked oth treumatic even To Be	19a. Informant's Name/Relationship (Ty)	•	19b. Mailing Address (Street and Number or F 314 Todd Place NE	Rural Route Number, City	
Baltimore, Moser, Ind. Sermit. Pages 1 and 2 Department of Heelin Important: If item 27 in it in injury or other trues.	Nannie Gilliam 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	20b. Pla emoval from State	ace of Disposition (Name of metery, crematory or other place) erdale Pk Crem Feb	Date 20c. I	ocation - City or Town, State
Baltimore permit. Pages 1 Department of H Important: If its any injury or of	21. Signal in of Funeral Service Licent	boune	22. Name and Address of Facility Tyrone J. Youn	g 719 Kenn	nedy St. NW 20011
Physician	23a. Part1. Enjer the disease, or coupli shock of heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	CAR	Do not enter the mode of dying, such as cardi 1) IAC BAR 4y +14 M/ /L		Approximate Interval Between Onset and Death 2 M-1
/Medical Examiner	Sequentially list conditions, if any, leading to immediate		PERIVATREMIA - 1 ence of):		rymint Tweek
68760, ificate be executed g physician and as the burial-transit edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ence of:	BOTION	
of Vital Records, P.O. Box 68 Physician: The law requires that the death certific this certificate has been signed by the attending pl ral director, page 2 should be detached for use as t TO Be Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
rds, P quires that n signed b uld be deta		atributing to death but not results	lting in the underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
I Record The law require cate has been signage 2 should I	i .	•	WLCFAS.	24a. Was an autopsy performed? 1 □ Yes 2 □ N	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital Sicien: Certifica inector, p	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 E		eath (Check only one) Home 5 Residence	6 DOther (Specific)
Division of Vital Records, To the Hospitel or Attending Physician: The law requires the within 24 hours after death. To the Funerel Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be demonstrated. Medical Certification; To Be Completed by	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M 1 Yes 2 No	28d. Describe how inju	
Division c itel or Attending P its after death. rel Director: After t led in by the funers Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, le)
o the Hospit thin 24 hour to the Funer mpletely fill Medical (vledge, death occurred at the time, date and plate on and/or investigation, in my opinion, death occurred.		
To the within to the comp	29b. Signature and title of certifier	B. Inghan	29c. License number 75891		ate signed (Month, Day, Year)
State	30. Name and address of person who concluded Roger M. Ingh		Kenilworth Ave Su	ite 2400	Riverdale Md.207

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004, 07620 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** (server 1:20 A M ehruhry 08,700 (nomers /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Courffy of Deet Examiner Cheverly Prince Georges Hospital Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 05-05-1951 Washington, D.C 579-68-1845 52 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-f show amy injury or other traumatic event, it a Medical Examples much be confilled at once. 1X Yes 2 □ No Maryland Prince Georges Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5611 Rollins Lane 20743 U.S.A. by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 11th Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theodore Garner Delores Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5611 Rollins Lane 19a. Informant's Name/Relationship (Type, Print) LaShawn Lewis/ Daughter Capitol Heights, Maryland, 20743 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crem. 02-14-04 Riverdale, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 3447 14th St., N.W. Wash., D.C. 20010 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Physician aneurusu /Medical **Examiner** rover Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death P.0 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Abuse 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 patient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation Natural within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI who completed cause of death (Item 23a) (Type, Print) 7525

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 8 2004

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Feb. Day Geraldine Mae Griffith 13 2004 7:19 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 31, 1939 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🗓 F 215-70-9521 64 Yrs. Director Wash., D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits other then "natural", or Items 23e or 28e-f shovent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9008 Cheva1 Lane 20772 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give A Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerical U.S. Census Bureau 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Is marked ပ Bernard Francis Scheppach Helen M. Vogel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau 2006. Christine Musselman / daughter 1529 Fenway Road Crofton, MD. 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 2-18-2004 Clinton, MD. 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Highway Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Neumunia /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a con uence of): The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medlcal as anding I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 DEctopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 ☐ Yes 2 ☐ No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy 1 ☐ Yes 2 2 No 1 Yes Division of Vital or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 patient 2 ER/Outpatient 3□ DOA After thi funeral 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature title of certi 29¢ License number 29d. Date signed (Month, Day, Year) 200 L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) لعو Nich 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

				artment of Health and Mental Hy <i>rtificate of Death</i>	giene 2004 07622
			Decedent's Name (First, Middle, Last)	2. Date of De	aath 3. Time of Death
	Physic		Mollie V. Gaskins	Febru	ary 9, 2004 10:17A
, de	/Medi Examii		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Southern Maryland Hospital	Clinton	P.G.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8, Date of Bir	th 9 Birtholece (State or Foreign
	Director		577-36-0554 1 1 M 2 T 86 Yrs.	Months Days Hours Min. (Month, Days Sept.	
	p ,		Usual Residence of Decedent		
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	with the Maryland e or 28e-f show	1	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	death v	Funeral Director	3515 Melrose Avenue	20747	United States
	er de	nu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
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	filed Hygi other		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	G S I
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S	d 2 s th ar trau		Brand Brand 1 3515	Melrose Avenue	er, City of Town, State, Zip Code)
ရှ	1 and Health Iem 27		Pore Fore	stion (Name of natory or other place)	20c. Location - City or Town, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours alter death with Department of Health and Mental Hygiene. Inportant: If Item 27 is marked other than "natural", or Itams 23e or any injury or other traumatic avent, the Moucal Examinat must be once.		'4 □Donation 5 □Other (Specify) Resurred 21. Signafure of Funeral Service Licensee 4	ction Cem. 2/16/04	Clinton, Md.
Ba	permit. Page Department of Important: If any injury of once.		Marian Edunal	Name and Address of Facility Hodges &	Edwards F.H.
	m16		23a. Pag1. Enter the disease, or complications that caused the death. Do not ent	910 Silver Hill Rd.Su	rrest, Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	in the mode of dying, such as cardiac of respiratory as	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	hemorrhage	
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ă	atter for u	clar	If the past 12 months:	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
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٩	The law requires that the death certificate has been signed by the attending lange 2 should be detached for use as	Į V	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?
ds	uires sign id be	d by	Hypertension	1 🗆 Y	res 2 □ No 3 □ Probably 4 ☑ triknown
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of	F F F	-	1 ☐ Yes 2 ☐ R/Outpatien 2 ☐ RR/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursing Home 5 Hesid	lence 6 Other (Specify)
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Division	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be 28e Place of Injury - At home farm stre		treet and Number or Rural Route Number,
Ö	after Dire	Certification;	4 Homicide determined 286. Place or injury - At nome, farm, street building, etc. (Specify)	City or Tow	n, State)
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier Physician: To the best of my knowledge, death	occurred at the time, date and place, and due to the o	rause(s) and manner as etated
	24 h 24 h Fur etely	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or inv	restigation, in my opinion, death occurred at the time, of	date and place, and due to the cause(s)
	o this	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	F > F 0		heart R Diemais	D0053813	02/09/04
0	F-		30. Name and address of person who completed cause of death (Item 23a) (Type, I		/ / / /
K	- (5)		Mark R. Dumais 7503	Surralts Road C	lister MM
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- 0110113 1-300	
	Registr		FEB 1 7 2004 Bleek & Spark		
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State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 22, **Physician** February 2004 10:20 a^M Elizabeth Graham /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LaPlata Center Gensis Elder Care LaPlata Charles County 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar. 5, 19 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 88 1915 South Carolina Director 579-28-3534 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 ☐ No Directo Maryland | Charles County LaP1ata 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? r than "natural, or Itams 23a or tre Medical Examiner must be 20646 United States One Magnolia Drive death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X No Specify: Black þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3rd Chef Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be f nent of Health and Mental P int: If item 27 is marked of Tom Brooks Octativa Spearman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma White / Daughter 9610 Wedgewood Dr. Ft. Washington, Md. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 2/28/04 Clinton, Md. Alexander S. Pope Funeral Home 21. Signature of Funeral Service Licensee wette ! CYC 5538 Marlboro Pike Forestville, Md. 20747 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre Approximate Interval Betwe Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last consequence of) Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 20 No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe q 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed? certificate 2 TNo 1 Yes 2 No 1 Tyes or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No in by the **Director**: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I To the Hospital Vicertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year, no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person KO MGK M 32. Registrar's Signature 31. Date filed (Month, 4 2004 State Registrar

ORIGINAL

y Green	•	1 - For State Registrar	State of Maryland / Depa	artment of Health and tificate of Death	Reg	No. 2004 07624
Phys	sician	Decedent's Name (First, Middle, Last) Troy	Green		2. Date of Death Month February	Day 2004 3. Time of Death 0016 a M
	edical miner		street and number)	4b. City, Town, or Location of Dea Cheverly		4c. County of Death Prince Georges
Fune		5. Social Security Number 6. Sec		If Under 1 Year If Under 24 Hrs Months Days Hours Min		
D		Usual Residence of Decedent 10a. State 10b. County	Georges 10c. City, Town or Lo	cation Mar1boro 10f. Zip Code		10d. Inside City Limits 1 StYes 2 □ No Citizen of What Country?
th with	aiD	11007 Bennington D		20772		Inited States
ING 21215-UU36 be filed within 72 hours after death with the Marylan tal Hygiene. Ital Hygiene. on other than "natural", or items 23s or 28s-f show wont. It wendteal Examine must be notified as even	d by Fune	3 ☐ Widowed 4 ☐ Divorced	MXYes 2 □ No1/11/83 If Yes, Give Year or Dates: 9/4/86	Was Decedent of Hispanic Origin? (: 1 Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc. Specify: Black
within 72 tene.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. Decer e completed) (Give College (1-4or 5+)	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) Sheriff	orking	b. Kind of Business/Industry County Government
filed in Hygin	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Maid	
aryland should be file and Mental Hy marked oth	To B	Walter J. Green			rie Johnson	
Mar and 2 sh alth and 27 is m		19a. Informant's Name/Relationship (Ty Cheryl Green / Sp	ouse 11007	Bennington Dr. U	Jpper Marlb	oro, Md. 20772
Saltimore, I sermit. Pages 1 and Department of Healt mportent: If item 2		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from State 20b. Place of Dispo cemetery, crei Maryland	sition (Name of natory or other place) Veterans Feb		c. Location - City or Town, State
Baltimore, permit. Pages 1a Department of He Importent: if item	once	21. Signature of Funeral Service Licens	22 MO/08 22	Name and Address of Facility	Funeral E	Tomes Md. 20747
Physici: /Medic	an		is ions that caused the death. Do not ent		c or respiratory arrest,	Approximate Interval Between
cate be executed cate be executed by sician and the burial-transit	er j	Sequentially list conditions, france leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
. Box 6 death certifi e attending	lan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		Ectopic pregnancy		23d. Date of delivery Month Day Year
S, +	À	Faith. Other significant conditions co.	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? w o 3 ☐ Probably 4 ☐ Unknown
The The ate h	omo				24a. Was an autopsy performed	prior to completion of cause of
Of Vital R Physician: The rthis certificate h	90		Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Othor	eath (Check only one)	e 6 □Other (Specify)
			28a. Date of Injury (Month, Day Year) 28b. Time o		28d. Describe how i	
5 p # 2 5	1 2	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
To the Hospital or within 24 hours afte To the Funeral Dir.	edical (29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ XMedical Exami one)	sicien: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.			
To the Vithin 2	M	29b. Signature and title of sertifier	1	29c. License number CCME		Date signed <i>(Month, Day, Year)</i> February 21 2004
No		1 1 1	empleted cause of death (Item 23a) (Type,	Print) 111 Penn Stre	et, Baltim	ore, Maryland 21201
	State	De Dete Glad (16 ath Day Van)	22/Denistrar's Signature	role)		

		For State	State	of Maryla		artment of H		lental Hyg	iene 19. No. 200	1. 07625
		Registrar 1. Decedent's Name (First, Middle)	la Lasti				Jeani	2. Date of Deat		3. Time of Death
Physic /Medi		Walter	Gallion	Jr	•			Month	6, 2004	
Exami		4a. Fecility Name (If not institution	n, give street and no	umber)		4b. City, Town, or	Location of Death		4c. County of De	eth
		Southern Mar					nton		P.G.	
Funeral Director		5. Social Security Number 230-32-3867	6. Sex 1 X M 2 ☐ F		rs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 3	Year) C	rthplace (Stete or Foreign country) VA
P .		Usual Residence of Decedent		10-	O:- T	***				
or death with the Maryland teme 23a or 28s-f show or riths to rediffed at	-	10a. State 10b. County		100.	City, Town or Lo					10d. fnside City Limits 1 ☑ Yes 2 ☐ No
Ba-f s	Director		P.G.		Clin					
ith th	Dire	10e. Street and Number	T			10f. Zip Code	3 F	10	Og. Citizen of What C	,
ath v	ral	9211 Stuart		- Hank Countin	116 42	207:		soitu Vas ar Na	14. Race - Am	ed States
er de item	Funeral	11. Marital Status	Armed F	cedent Ever in orces?	10.5.	Was Decedent of H If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Wh	
hours after tural; or ite	by F	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2 No 19 Sive Dates: 194	46-	1 ☐ Yes 2 ☑ No	Specify:		Specify:	lack
thou stura		15. Deceder	nt's Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	
filed within 72 ho Hygiene. other than "natu	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed	(1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work)	ing		
d with giene	Eo	12	College	(1-401 54)		Nurse		I	OC Gener	al Hospital
be filed within tal Hygiene. Id other than event, the Me	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Name	e (First, Middle, M	Maiden Sumame)	
vlents Vlents rrked	To	Walter Gall	ion Sr.				Missou	ri Free	eman	
id 2 should be fi th and Mental H 27 is marked of traumatic ever	ji,	19a. Informant's Name/Relations			19b. Maili Q 7 1 5	ng Address (Street	and Number or Run	al Route Number,	City or Town, State,	Zip Code)
and and n 27		Willie Gall	ion/brot		Fort	Underw Washin	gton, M		N. 1781	
of He of He or oth		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from		o. Place of Dispo cemetery, cre	osition (Name of matory or other place		Date	20c. Location - City o	r Town, State
Peges ment of ent: If it		* 4 □ Donation 5 □ Other (S				Mem. Pa			Landover	
permit. Peges 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra once.		21. Signature of Funeral Service	Licensee						Edwards	
7 70 2 4 9		finice	Zour	ude						, Md.20746
		23a. Part1. Enter the disease, o	r complications that t only one cause on	caused the de	eath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate fnterval Between Onset and Death
Physician		fmmediate Cause (Final disease or condition	_ a/	Sep to cer	mig					Onsor and Boath
/Medical Examiner		resulting in death)	Due to	o (or as a cons	equence of):					
Ladiffile		Sequentially list conditions,	b. — Due to	o (or as a cons	oguana of):					
be tis	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Due it	o (or as a cons	equanca or).					
be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c	o (or as a cons	equence of):					
be e sicien buris	dical E									
ficate physis the	adic		0.							
eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of preg					23d. Date of de	elivery
death death d for	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Preg	i birth 2 □ Fi gnant at time o		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			Month	Day Year
that the de	hys	9 🗆 Unknown	9□ Unk	nown						
res tha igned be det	by P	Part II. Other significant condit	ons contributing to	death but not r	resulting in the u	inderlying cause give	en in Part I.			to the cause of death?
w require been sig should b								1 ☐ Ye	ıs 2⊡—Ko 3∏ F	Probably 4 Unknown
The law requires that the death certificate the has been signed by the attending physpage 2 should be detached for use as the	Completed							24a. Was ar		autopsy findings available completion of cause of
The I	E							perform	ned? death?	
ysician: Th	Be	25. Was case referred to medical examiner?	31				26. Place of Deat			
dis ye	10	1 ☐ Yes 2 ☑ No	Hospital: 1 🖫	Inpatient 2	☐ ER/Outpatie		4 Linuising no	me 5 Reside	nce 6 Other (Sp	ecify)
ng Ph Ifter th	on:	27. Manner of Death 1 ☑Natural 5 ☑ Pendi	28a. Date (Mc	e of Injury onth, Day Year,	28b. Time of Injury	Worl		28d. Describe ho	w injury occurred	
eath.	cati		ligation				Yes 2□No			
or At fter d direct in by	Certification:		mined 289. Plat	ce of fnjury - A ding, etc. <i>(Spe</i>	t home, farm, st ecify)	reet, factory, office		28t. Location (Sti City or Town	reet and Number or F I, State)	Rural Route Number,
pital urs a eral		200 Constine 17 Consider	na Shusiaian. Ta ti	ha hast of my !	annulades desi	h	no data and place	and due to the co	was (a) and manner	an stated
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical		Examiner: On the						use(s) and manner a ate and place, and du	
o the	Σ	29b. Signature and title of control	er /			29c. Licens	e number	25	9d. Date signed (Mor	nth, Dey, Year)
F S F Ö		Na.	bone un)		D 00	55120		FES 17 2004	
DI	0	30. Name and address of person	who completed ca	use of death (I	tem 23a) (Type	Print)				
- U 1.V	7	Richard Palere	1 GN -	328 South	em Ave	se sute	310 Wahin	ghon DC	20032	
	tate	31. Date filed (Month, Day, Year FEB 2 5 2	004	Registrar's Sig	gnature	. oi.				
Regis	traf	LFR 72 T	JUT DE	Me A	LA DEA	W.				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No. 2004 0762
Physician /Medical	Daisy M. Huffman Feb	26, 2004 2105
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Ruxton Health of Denton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date	Caroline
Funeral Director	233-28-4957 To the second residence of Decedent 1 M 25 F R 3 Yrs. Months Days Hours Min. 111/	of Birth (Country) 9. Birthplace (State or Foreign Country) W. Virginia
Marylene a-f show the dall	MD Caroline 10c. City, Town or Location Denton	10d. Inside City Limits 1 ★Yes 2 No
offer deeth with the Ma writems 23a or 28a-1s riner must be notified Funeral Director	10e. Street and Number 10f. Zip Code 420 Colonial Drive 21629	10g. Citizen of What Country? United States
urs efter des al', or items Examiner m by Fune	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Specify Cuban, Mexican, Puerto Rican, et 1 Yes, Specify: 1 Yes 2 No Specify:	or No- c.) 14. Race - American Indian, Black, White, etc. Specify: White
permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Health and Mantal Hygiana. Important: if flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once. To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business/Industry Own Home
weld be filed Mantal Hyg irked other affic event,	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, M	
nd 2 shou lith and M 27 is mar r traumat	19a. Informant's Name/Relationship (Type, Print) Margaret H. Daye/Daughter P.O. Box 284, Preston,	
Pages 1 ei nant of Hea int: If Item	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State /04 Federalsburg, MD
permit. Departrimports any inju	21. Signature of Funeral Service Licensee Wilhard 7- Galary PO Box 43, Federals	om Funeral Home,P.A. burg, MD 21632
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Approximate Interval Between Onset and Death
ertificate be executed fing physicien and se as the buriat-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):	
death of attanced for us	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b.	Did tobacco use contribute to the cause of death
r requires that the death certific been signed by the attending p should be datached for use as leted by Physician/Mex	Congestive heart failure	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknow
sian: The law requires thet the death cer artificate has been signed by the attendir octor, page 2 should be datached for use Be Completed by Physician/A	24a.	Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
in: The lifticata h	25. Was cese referred to medical 26. Place of Death (Check	1 Yes 2 No
hysic his ca il dire	examiner? Yes 2 No	Residence 6 □Other (Specify) cribe how injury occurred
the Hospital or Attending P thin 24 hours efter death. the Funeral Director: Attar ti mpletely filled in by the funeral Medical Certification:	4 ☐ Homicide building, etc. (Specify)	tion (Street and Number or Rural Route Number, or Town, State)
he Hospital in 24 hours of the Funeral i pletely filled edical Ce	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the and manner stated.	o the ceuse(s) and manner as stated. time, date and place, end due to the cause(s)
To the within 2 To the comple	29b. Signature and title of certifier 29c. License number 00047534	29d. Date signed (Month, Dey, Yeer) 2/29/04
	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Wafik Zaki, M.D. 920 Market St., Denton, MD 216	529
State Registrar	31. Dete filed (Month, Day, Year) 32. Regristrar's Signature	

DHMH 17 Rev 1/2001

Registrar

FEB 1 9 2004

			1 = For State Registrar	State of Marylan		artment of H		-	giene 004	07628
	Physic	an	1. Decedent's Name (First, Middle, Last					2. Date of De		3. Time of Death
	/Medi		Harold Joseph					Februar	y 13 200	4 12:24 AM
	Exami	ner	4a. Facility Name (If not institution, give 1608 Rock Creek D	,		4b. City, Town, or 21702	Location of De	eath	4c. County of Dea	
	Funeral		5. Social Security Number 6. Sec		last birthday)	If Under 1 Year	If Under 24 F	Irs. 8. Date of Birt	Frederi	
н	Director			M 2□F	81 Yrs.	Months Days		in. (Month, pa July 18	1922 Mar	thplace (State or Foreign ountry) yland
_	pu >		Usual Residence of Decedent 10a. State 10b. County	140-00	y, Town or Lo			7017	, , , , , , , , , , , , , , , , , , , ,	
	Aaryla f sho	ö	Maryland Freder		ederic					10d. Inside City Limits 1 X Yes 2 □ No
	the h	Director	10e. Street and Number	TCR T1	edel 10	10f, Zip Code			10g. Citizen of What C	
	h with	Ö	1608 Rock Creek D	rive #5		21702		1	United Sta	•
	death	Funeral		12. Was Decedent Ever in U. Armed Forces?	S. 13. V		spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Am	erican Indian.
36	or Ite	by Fu	1 ☐ Never Married 2 ☐ Married	1 Yes 2 □ No WW I	II ;	i res, specily cubar I ☐ Yes 2 🖾 No	Specify:	eno Hican, etc.)		te, etc. White
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show he Madical Examinar must be notified at	ed b	3 Midowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:						
75	nin 72 n "ne	Completed	(Specify only highest grade	e completed)	(Give	lent's Usual Occupa kind of work done d OO NOT use retired)	uring most of v	vorking	16b. Kind of Business	/Industry
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pu	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)					lame (First, Middle,	Maiden Sumame)	
Maryland	1 Men narke	၉	James Franklin Ha					cLucas		
Ma	d 2 st th and 17 is n treun	10	19a. Informant's Name/Relationship (Ty) Joleen Hart/Daugh	-					r, City or Town, State, 2	
ē,	theal		20a. Method of Disposition		lace of Dispos	TISO(1 PIE sition (Name of natory or other place	ice/fre	Date Date	aryland 21	
E O	Pages entol nt: If i		1 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	dinoval noin otato		iatory or other place Cemetery		uary 16 2014	+ Hagerstown	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Insportent: If item 27 is marked other then "neturel; or Items 23a or 28e-f show any injury or other treumatic event, the Markinal Examinat must be notified at once.		21. Signature of Funeral Service License	772		Name and Address		Struffer Fo	neral lines,	P.A.
<u> </u>	89 = 8		Marianne	H. Stay				e/Frederick	, Meryland 21	702
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death	Do not ente	r the mode of dying	, such as cardi	ac or respiratory arr	est,	Approximate Interval Between
E	Physician		Immediate Cause (Final disease or condition resulting in death)			-YMPHON	A			Onset and Death
	/Medical Examiner		Tooling in death,	Due to (or as a consequ	ience of):	erne Le	PILCH	11		CYCANO
		<u>a</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ		TVIC LE	UNCE	177		3 /4/16
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ö,	be executed sician and burial-transit	Ex	resulting in death) Last	Due to (or as a consequ	ence of):					
8760,	icate be executed physician and s the burial-transit	dicai	d							
Ψ		Me	IF FEMALE:	3c. If yes, outcome of pregnar	201/					
. Box	death certifi e attending id for use as	Physician/Me	in the past 12 months?	1 Live birth 2 Fetal	death 3 □	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	0 0 2	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		Cirier (apechy)				
o,	law requires that the as been signed by the 2 should be detache	by P	Part II. Other significant conditions conf	tributing to death but not resu	lting in the und	derlying cause given	in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Vital Records,	w require been sig should b							1 □ Ye	s 2 XNo 3 ☐ Pro	obably 4 Unknown
Se .	law r las be	Completed						24a. Was ar	24b. Were au	topsy findings available ompletion of cause of
E ,	cate has	ខ្ល						perforn	jed? death? DANo 1 ☐ Yes	2□ No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	rnysicien: In this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				ath (Check only one	-	
ō	ral di	2	1 ☐ Yes 2 No	1 Inpatient 2 E	R/Outpatient 28b. Time of	3 DOA Other	4 🗆 Nursing	Home 5 Reside	nce 6 Other (Spec	ify)
5	Attending are death. ector: After by the funer	tio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury a Work? M 1 ☐ Ye	is 2 □No	280. Describe no	w injury occurred	
DIVISION	after death. I Director: After d in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (Str	eet and Number or Ru	ral Route Number,
5 }	rs after or rel Dir	Cer						City or Town	ŕ	
	within 24 hours at To the Funerel D completely filled in	edicai	29a. Certifier (Check only one) CETCertifying Physical Examine	ician: To the best of my know er: On the basis of examination	rledge, death on and/or inve	occurred at the time, estigation, in my opin	, date and place	e, and due to the ca urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
4	ithin 2 o the	Med	29b. Signature and title of certifier	and manner stated.		29c. License r			d. Date signed (Month)	
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9	10	-	30. Name and address of person who con	npleted cause of death (Item :	23a) (Type, Pi	rint)			(/	
_			BRIAN M. O'GN	NON MAS 50	5/ W.	SEVENTA	L 57.	FREDER	ICK MO	2170/
*	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire	and I	,	/		
			EED 1 Q 20	NA PROPERTY.	A RATE					

			1 - For State of Maryland / Dep	partment of Health and I ertificate of Death		ene 004	07629
1	81		Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Media		Leo George Hruska		Februar		4 2:20A ^M
	Examir	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Deat	
			9479 Canary Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Bel Alton If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Char	les
	Funeral Director		579-05-6224 1 M 2 F 90 Yrs.	Months Days Hours _ Min.	uary 18	1914 Was	shingtonDC
	P .		Usual Residence of Decedent			, = , = , , , , , ,	
	anylar show	7	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-1	ecto	MD Charles Bel	Alton 10f. Zip Code	10	g. Citizen of What Co	
	3a or	0	9479 Canary Drive	20611	,	USA	undy:
	death ms 2;	Funeral Director		. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic svent, itte Medical Examiner must be notified at once.	by	1 ☐ Never Married	1 ☐ Yes 2 ☐ No Specify:	o Hican, etc.)	Black, White	White
5	72 ho	Be Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Girls)	edent's Usual Occupation e kind of work done during most of work	kina 1	6b. Kind of Business/l	ndustry
2	vithin nen han	mple	Slementary/Secondary (0-12) College (1-4ex 5+)	DO NOT use retired)	9	Motor T	
i D	Hygie Hygie ther t	Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, M	Metro I	ransit
Maryland	d be and a company of	To Be	Joseph Hruska	Anna G		aroon Somamoy	
ary	shou ind M i mar umatl	-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number or Ru	ral Route Number,	City or Town, State, Z	ip Code)
	and 2 balth a n 27 ls		Alice Hruska/Wife 947	9 Canary Dr. Be	el Altor	.MD 2061	.1
ore	of He of He if item		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition 20c Amethod of Disposition	ematory or other place)		Oc. Location - City or	
altimore,	tment tant: jury o		'4 □Donation 5 □Other (Specify)	natius Cem. 2/28		Port Toba	
Ba	permil Depar Impor any in		have C. Ehal	AREHARTSECHOLS P.O. BOX 567 LA	A PLATA.	MD 20646	Α.
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Denentia			y245
	Examiner		Due to (or as a consequence of):				,
0	**	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	cuted	Examiner	if ally, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
Ó,	e execian ar		resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dicai	d				
9	ding p	0	IF FEMALE: 23c. If yes, outcome of pregnancy			and Data of dalls	
Вох	that the death certificed by the attending of	Physician/M	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delin	Day Year
o.	t the c by the achec	hysi	9 Unknown				
o. O.	res tha igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the			icco use contribute to	the cause of death?
ord	w require been sig should b	ted	Lur Arong chatty 1 sohen	ic heart diseas	1 Yes	2 □ No 3 □ Pro	bably 4 Unknown
Records,	has be	Completed	Drasefes mellitus		24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
E E	ysician: The lis certificate hadirector, page	Con			performe 1 ☐ Yes 2		2 No
Vita	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner? Hospital:	Other	th (Check only one)		
ō	Attending Physician: The law requires that the death certific redeath. ector: Atter this certificate has been signed by the attending is by the funeral director, page 2 should be detached for use as	-	27. Magner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	ome 5 XResiden 28d. Describe how	ce 6 Other (Speci injury occurred	ify)
o	nding ath. r: Afte e fun	atlo	1	Work? M 1 ☐ Yes 2 ☐ No			
Division of	r Atte	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
	urs affurs affur		V				
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or and/manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)
1			19 4	D33426		2/25/0	<u> </u>
(12. 111		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	2 MD 20	61.6	
D) L Sta	to	Larry Jenkins, M. D. 111 La Gra 31. Date filed (Month, Day, Year) 32. Refistrar's Signature	nge Ave La Plat	a,rib 20	040	
	Registr		31. Date filed (Month, Day, Year) FEB 2 7 2004 32. Refistrar's Signature	perk			

Henckel, Linda F.

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220. S. HARRISON, MD 21601 Approximate forms of control of the co	or oth	2	20a. Method of Disposition	_	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other place		2	0c. Location	- City or To	wn, State
220. S. HARRISON, MD 21601 Approximate force or heart fature. List only one cause of seath inc. and the desart. Due to (or as a consequence of): 232. Part. Emer he disease, or complications that caused the death. Due to death the mode of dyng, such as cardiac or respiratory arrest, increased a death one, or heart fature. List only one causes on seath ine. The part of the mode of dyng, such as cardiac or respiratory arrest, increased and the death. Due to (or as a consequence of): 232. Part. Emer he disease, or complications that caused the death. Due to dyng, such as cardiac or respiratory arrest, increased and the death. Due to (or as a consequence of): 232. Part. Emer he disease, or complications and the death. Due to dyng, such as cardiac or respiratory arrest, increased and the disease of dyng, such as cardiac or respiratory arrest, increased and the disease of dyng, such as cardiac or respiratory arrest, increased and the disease of dyng, such as cardiac or respiratory arrest, increased and the disease of dyng, such as cardiac or respiratory arrest, increased and the disease of dyng, such as cardiac or respiratory arrest, increased and the disease of dyng, such as cardiac or respiratory arrest, increased and the disease of dyng, such as cardiac or respiratory arrest, increased and the disease of dyng, such as cardiac or respiratory arrest, increased and the disease of dyng, such as cardiac or respiratory arrest, increased and the dyng, such as cardiac or respiratory arrest, increased and the dyng, such as cardiac or respiratory arrest, increased and the dyng, such as cardiac or respiratory arrest, increased and the dyng, such as cardiac or respiratory arrest, increased and the dyng, such as cardiac or respiratory arrest, increased and the dyng, such as cardiac or respiratory arrest, increased and the dyng, such as cardiac or respiratory arrest, increased and the dyng, such as cardiac or respiratory arrest, increased and the dyng, such as cardiac or respiratory arrest, increased and the dyng, such as ca	jury o		* 4 □ Donation 5 □ Other (Special	ify)	TII				-21-20	04 TII	LGHMAN	, MD
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Cause. Enter Underlying Physician: To the basis of examination and/or investigation. Cause	iner			b								
FEMALE 23b. Was decedent pregnant 1 21c. If yes , outcome of pregnancy 1 21c. If yes 2 3d. Date of delivery 3d. Date of	=	ner	if any, leading to immediate cause. Enter Underlying	Due to (c	or as a conseq	uence of):						
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FEMALE 23b. Was decedent pregnant in the past 12 months? 1	burial	E E			or as a consequ	dones on.						
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24a. Was an autopsy findings a prior to completion of cedebre and place and due to the cause(s) and manner as stated. 24b. Were autopsy findings a prior to completed cause of death (Check only one) 25c. Was case referred to medical examiner? 1 Yes 2 Mo 26c. Place of Death (Check only one) 27c. Manner of Death 27c. Injury at powers 27c. Injury at powers 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number of	letached for use	Physi	9 Unknown	9☐ Unkno	wn			ven in Part !	23a Did tob	acco use con	atribute to th	a cause of death
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID SMITH M.D. 29466 PINTAIL DRIVE, EASTON, MD 21601 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ineral director, page 2 should be d	Certification: To Be Completed by	9 Unknown Part II. Other significant conditions. 25. Was case referred to medical examiner? 1	Hospital: 1 In 28a. Date of (Month) 28e. Place building thysician: To the sminer: On the ba	ath but not resident at his patient 2 finjury, Day Year) of finjury - At his, g, etc. (Specification of my known sis of examina	ER/Outpatien 28b. Time of Injury ome, farm, str	ndertying cause given to a cause given t	26. Place of Death (C) ier: 4 □ Nursing Home y at 28d. Yes 2 □ No 28f. me, date and place, and	1 Yes 24a. Was an autopsy perform 1 Yes 2 heck only one 5 Resider Describe how	ed? 24b. ed? Ince 6 Ott vinjury occu seet and Num. State)	3 Prob Were autoprior to cordeath? 1 Yes her (Specify	abiy 4 Unkr psy findings avai mpletion of cause 2 No //
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State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Howilton ,2004 marles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner alven Hospita Ca If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months **™** M 2□ F 1917 Maryland 216-20-5986 86 19, Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Items 23a or 28a-f show the Modical Examiner must be notified at 1 ☐ Yes 2X No Maryland Howard Columbia Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 5830 Humblebee Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [XYes 2 □ No If Yes, Give Year or Dates: 1943–45 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nen of Health and Mental Hygiene.
nn: If item 27 is marked other than "natural; or flee irry or other traumatic event, Ita Modical Exeminary or other traumatic event, Ita Modical Exemina 1 Never Married 2 Married Specify White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Educator Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Blanche Morris Charles Edward Hamilton ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5830 Humblebee Road Columbia. Maryland 21045 Dorothy G. Hamilton/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20, 2004 Bayview Crematory permit. Pag Department Important: I any injury o Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses Going Homes Cremation Service P.O. Box 784 la Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3□ DOA 2 this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: : After I 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 96120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deleon 10 31. Date filed (Month, Day, Year) State 20 FEB 2004 Registrar

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	Funeral Director		5. Social Security N 240-72-79 Usual Residence of	32	1 XM	1 2□F	7. Age (II	58	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, p June 1	3, 19	45	Coun	lece (State or Fol try) Caroli	
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and	ould be f Mental I arked of atic eve	To Be	Joseph		,	ī	Hampt	on				Juli						on	
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\mathcal{L} altimore,	permit. Pages 1 a Department of He: Important: If item any injury or othe		1 X Burial 2 €	☐ Cremation 3 5 ☐ Other (See		noval from	State .		urreci				2/27	/04	Cli	nton	,Mary	land	
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			30. Name and ad in	ess of person w	ho com	pleted cau	se of death	h (Item	23а) (Туре,	Print)						V			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 23, 2004 6:45 A M Joseph Andrew Hill, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 42910 St. Andrew's Church Road Leonardtown St. Mary's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 84 1X1M 2□ F 218-14-3337 Maryland Director August 17, 1919 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County or than "natural", or items 23s or 28s-f show the Medical Examiner must be nutified at 1 X Yes 2 □ No St. Mary's Maryland Leonardtown Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 42910 St. Andrew's Church Road 20650 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Mason Construction permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edmond T. Hill Sarah Bobber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John Henry Hill/Son 3071 Donegal Court Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/27/2004 Queen of Peace Helen, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 270 Leonardtown, MD 20650 Thichael Kircie 23a. Pert1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage 14 months Extensive small Cell lung Conce **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner physicien and s the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical the attending posterior as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death Dav Year in the past 12 months? Month 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 0 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? has certificate 1 ☐ Yes 2 🗆 No 1 Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this within 24 hours after death.

To the Funerel Director: After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending Injury 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 50600 2/23/04 ashaba 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOBUL OUT ROAD, LEONAMOTOWN, MD LOBSO Guratte.S. LITHABAA 25560 POINT 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 5 2004 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 07634 State PagistrarAMEND #1 PER FH CCHD 2/26/04 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARY LUCILLE JUPITER HARRIS Day Year **Physician** Feb. 21 2004 1:36 P^M MARY LUCILLE CHAPMAN HARRIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Civista Medical Center La Plata Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 👿 F FEBRUARY 12, 1929 MARYLAND Director 232-17-0891 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits Item 27 is marked other then "netural", or items 23a or 28a-f show other treumatic event. If a Medical Examinar must be notified at XXYes 2 No Directo MARYLAND CHARLES NEWBURG 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? P.O. BOX 175 20664 UNITED STATES Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 【XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 8TH GRADE ondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other them any injury or other treumatic event. If a Monce. HOUSEKEEPER HOME CARE 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) WILLIAM ARTHUR JUPITER MARY LUCINDA CHAPMAN JUPITER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 175, NEWBURG, MARYLAND REGINALD RAWLS / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) SHILOH CHURCH CEMETERY FEBRUARY 27, 2004 NEWBURG, MARYLAND 21. Signature of Funeral Services THORNION FUNERAL HOME, P.A. 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND LYDIA C. THORNIUN JOHNSON M00583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each fine. as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition Respirator **Physician** resulting in death) /Medical Examiner Obes 6Ven Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed the attending physician and the deruse as the burial-transit resulting in death) Last Due to (or as a consequence of)/ Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes Hospital or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 \(\tau \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Nnpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA this To the Funeral Director: After th completely filled in by the funeral 28a. Date of fnjury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 \ Homicide 24 hours 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an #11/6 D - 57708 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7-C Post Office Road, Waldorf, MD 20602 Abbas A. Omais, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

Harri

Mary

	1	For State Registrar	State of Maryland	/ Depa	artment of H	ealth and N Death	F	leg. No.		
Physicia /Medica Examine	in al	1. Decedent's Name (First, Middle, Last) Herman George Hart 4a. Facility Name (If not institution, give signs)	treet and number)			Location of Death	2. Date of Dea Month	Day 13 4c. County o	Yeer 2004 Deeth	County
Funeral Director		11721 Mockingbird 5. Social Security Number 162-14-5465 Usual Residence of Decedent	7. Age (In yrs. la	st birthday) 9 Yrs.	Hagers If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day January	Wasii. 18,191!	9. Birthplace Country) Penn	(State or Foreign
h the Maryland or 28a-f show		10a. State 10b. County Maryland Washingto 10e. Street and Number		Town or Lo Jersto				10g. Citizen of W		Inside City Limits 1 ☐ Yes 2 No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, Ind Modical Examinal must be notified at 2009.	by Funeral Directo	11.721 Mockingbird 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	Lane 2. Was Decedent Ever in U.S Amed Forces? 1♠ Yes 2 □ No If Yes, Give Year or Dates:	1	2174 Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No		pecify Yes or No- Rican, etc.)	U • S. 14. Race Black Specify:	·A. - American I t, White, etc. Whit	
d within 72 hou giene. er than "natural ir e Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired altor	during most of work)		16b. Kind of Bus	tate A	
should be file and Mental Hyg s marked othe iumatic event,	To Be C	17. Father's Name (First, Middle, Last) Ernest L. Hartman 19a. Informant's Name/Relationship (Ty)	ne. Print)	19b. Maili	ng Address (Street	18. Mother's Nam Ethel W	olfort			de)
es 1 and 2 s of Health an if item 27 is prother traus		Marguerite J. har 20a. Method of Disposition 1 X Surial 2 Cremation 3 CR	tman 20b. Pla	117 ace of Dispo		ngbird L	ane Hage	erstown,	Maryl City or Town.	and 217
permit. Pages Department of Important: If it eny injury or o once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			2. Name and Address 1331 East	ss of Facility Do	uglas A.	Fiery 1	Funera	1 Home
death certificate be executed Examined and earliending physicien and for use as the burial-transit	ical Examiner	23a. Part1. Enter the disease, or complishock, or heart allure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	ence of):	ant M	elan	40 // v	rand	Int	proximate erval Between iset and Death
ath certifi ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[□Ectopic pregnancy			23d. Date Mon	of delivery th Da	y Year
v requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions cor	tributing to death but not resu	lting in the u	inderlying cause giv	en in Part I.	23e. Did to	obacco use contri		ause of death? y 4 □Unknow
The law ate has t page 2 s	Completed						1 ☐ Yes	osy p rmed? d 200 No 1	Vere autopsy rior to compleath?	findings availab etion of cause o
Attending Physician: Thraceath, r death, sctor: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Figure 1 27. Manner of Death 1 Matural 5 Pending investigation	26. Place of Dea en: 4 □ Nursing H y at k? Yes 2 □ No	ome 5⊠ esid	ne) dence 6 □Othe now injury occurre					
P S S S S S S S S S S S S S S S S S S S	I Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify, sician: To the best of my know			ne, date and place	City or Tov			
To the within 2 To the comple	Medical	(Check only 2 Medicel Examinate) 29b. Signature and title of certifier	ner: On the basis of examinat and manner stated.	ion and/or ir	29c. Licens	pinion, death occu	rred at the time,		nd due to the	e cause(s)
Sta	ite ar	30. Name and address of person who co	ompleted cause of death (Item 32. Begistrar's Signat	MD;	Print) (130	OPAL	- CT.	; Ha	Jersi	OWN, MI

			1 - For State Registrar	State of Maryla	and / Depa		Health and I	Mental Hyd	giene Reg. No. 200 L	07636
	Physici /Medi		Decedent's Name (First, Middle, Las DOROTHY ELAINE	t) HOLDWAY				2. Date of Dea		3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give 337 SUNBROOK LANE 5. Social Security Number 221-14-8353		rs. last birthday)			N	9. B	ASHINGTON ASHINGTON Inthplace (State or Foreign country) DELAWARE
	D	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND WASH		City, Town or Lo		AGERSTOWN		, 1922	10d. fnside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23a or 28 1st be not	al Direc	10e. Street and Number 337 SUNBROOK LANE			10f. Zip Code	21740	1	10g. Citizen of What C	U.S.A.
980	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28e-f show to Modical Exemirer must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Xwidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 1 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	within 72 ho iene. • than "natur ine Medical	ompieted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Deced (Give life.		pation during most of wor d) EMAKER	king	16b. Kind of Busines	
Maryland 2	should be filed nd Mental Hygir marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) JOHN CAMPBELL PEC				18. Mother's Nan UNKNO	WN	Maiden Sumame)	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23s or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7. JOHN HOLDWAY, SON 20a. Method of Disposition 1 Burial 2 Acremation 3 1 4 Denation 5 Other (Specify, 21. Signature of Funeral Service License	Removal from State S	6039 D. Place of Dispo cemetery, crer MITHSBU	MOSER RO sition (Name of natory or other pla RG CREMAT Name and Addre	DAD BOON COP 2/18 CORY 2/18 ess of Facility	SBORO M Date /2004 7606 O	20c. Location - City o	1713 TOWN, State , MARYLAND L PIKE
3760,	be executed with the price of t	ical Examiner	23a. Part1. Enter the disertie, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Unsur	b. Due to (or as a cons	eath. Do not ent	er the mode of dyir		or respiratory arr		Approximate Interval Between Onset and Death 20 YEARS
P.O. Box 68	The law requires that the death certificate be executed ate been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre- 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
	w requires that s been signed b should be deta	۾	Part II. Other significant conditions co	entributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.		bacco use contribute t es 2□No 3♠P	o the cause of death?
al Records,		Completed						24a. Was a autops perform	med2 prior to death?	utopsy findings available completion of cause of
ion of Vital	Attending Physician: The indeath. ector: After this certificate his ector: After this certificate his by the funeral director, page	atlon; To Be	27. Manuar of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 ☐ Nursing H		ence 6 Other (Special Countries of the C	acify)
Division	o afte	Certification:	3 Suicide 6 Could not be determined	building, etc. (Spe	ecify)			City or Towr		
	To the Hospital within 24 hours. To the Funerel completely filled	Medical	one) 2 Medical Exam	valcien: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	estigation, in my d	ppinion, death occur	rred at the time, di	ate and place, and du	e to the cause(s)
)	J with		29b. Signature and title of certifier	luws 2	MD	29c. Licens	634	d	9d. Date signed (Mon $2 - 18 - 2$	- 1/
25	r '		MATT BECK	ompleted cause of death (I		Print) 1140 HAC	M#DICK JERSTO	TW N	MD 2	1742
	Sta Registi	_	31. Date filed (Month) Day (Year) 2	004 32. Registrar's Sig	gnature S. S.	serte				

		1	For Stete Registrar	State of	Maryland	d / Depa <i>Cer</i>	irtment of H	ealth and M Death	1ental Hygi	ene 2 (104	07637
I			. Decedent's Name (First, Middle, L	ast)					2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Charles	Ea	rl		Hartung		Februar	/	2004	10:50 A ^M
	Examin		a. Facility Name (If not institution, ga	ve street and nun	nber)		,,	Location of Death		4c. County	_	
			730 Columbia Ave		7. Age (In yrs. I	ant highday)	Cumber If Under 1 Year		8. Date of Birth	Al	legan	LY lace (State or Foreign
	Funeral		6. Social Security Number 6. 214-12-3450	Sex 1∑M 2□F	7. Age (III yis. I	Yrs.	Months Days	Hours Min.	(Month, Day, 04/30/1	Year) 9.2.0	Coun	land
	Director		Jsual Residence of Decedent						0-17 307 1	720		
	yland now		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits 1 X Yes 2 □ No
	Mar Mar	ţō	MD Alleg	any		Cumbe	rland					
	or 28	Director	10e. Street and Number				10f. Zip Code		11	Og. Citizen of	What Cour	ntry?
	ath wi	rai	730 Columbia Av			0 40	2150		poitu Vas as Na-	USA 14 Ba	ce - Americ	an Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of Hy	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Dece Armed Fo 1) Yes If Yes, Giv Year or Da	2 No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2∑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		ck, White,	etc.
2-0036	hours fural	g	15. Decedent's		ates: WWI	16a Decer	dent's Usual Occupa	ation		16b. Kind of E		
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Maryland 2121	iene.	E	Elementary/Secondary (0-12)	College (1	-40f 5+)		Clerk			U.S. F	ostal	Service
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<u>a</u>	uld b Menta irked itic e	2	Phillip			Hartun	0		Catherin			
<u>a</u>	2 sho and I is me		19a. Informant's Name/Relationship	(Type, Print)			ng Address (Street					
≥,	and sealth m 27	0-	Lisa L. Hout/dau	ghter	20h B		1 Michael			nd MD 20c. Location		
Baltimore,	ges 1 t of H if ite	n i	20a. Method of Disposition 1 Deurial 2 Cremation 3		Ctata C	emetery, crei	matory or other place morial Pa	:e)	1	Cumber		
┋	t. Partmen tent: njury	1	4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Sun							Home, P.A.
Bal	Deparenti Deparenti Impo eny ir		21. Signature of Puretar Service Lic	elisoo ()	1 -12 -	/ "	404 Decat			-		21502
	31		23a. Part1. Enter the disease, or co	mplications that of	aused the deat	h. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arm	est,		Approximate Interval Between
10	Pnysician /Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a CORC	OVACY (or as a conseq	uence of):	TERY	DISET	4SE			Onset and Death
	Examiner	li			(5) 25 2 55,1554							
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8760,	ate b	edical	'	d							15.	
9	death certificate be executed e attending physician and od for use as the burial-transit	/Me	IF FEMALE:	23c. If yes, ou	tcome of pregna	ancy				23d. D	ate of deliv	ery
Вох	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?		ointh 2 ☐ Feta nant at time of d		□Ectopic pregnancy □ Other (specify)			N	lonth	Day Year
P.O.	that the de ned by the a detached t	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn	own							
	res that signed b	by Pi	Part II. Other significant condition	s contributing to d	leath but not res	sulting in the u	ınderlying cause giv	en in Part I.	23e. Did to			he cause of death?
rds	w require: been sig should b								1 🗆 Y	es 2,8 No	3 □ Prot	bably 4 Unknown
of Vital Records,	es es es	Completed							24a. Was a autops	SV	prior to co	opsy findings available ompletion of cause of
æ	o ← o	E C							perfor 1 ☐ Yes	med? 2⊠No	death? 1 ☐ Yes	2 🗆 No
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						ith (Check only or	10)		
<u>></u>	Physician: this certific ral director,	2	1 ☐ Yes 2XDXNo			ER/Outpatie	- Interior	4 Nuising I	ome 5 Resid			fy)
		on:	27. Manner of Death 1		of Injury oth, Day Year)	28b. Time of Injury	Wo	yat rk? Yes 2 ∐No	200. Describe II	OW INJURY OCC	21160	
isic	tent tor: the	icat	2 Accident investigat 3 Suicide 6 Could no	t be 390 Place	e of Injury - At h	ome, farm, s	treet, factory, office	100	28f. Location (S	treet and Nun	nber or Run	al Route Number,
Division	P # F =	Certification;	4 Homicide determin	ed build	ling, etc. (Speci	fy)	,		City or Tow	n, State)		
_	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier XXCertifying	Physicien: To th	e best of my kn	owledge, dea	th occurred at the ti	me, date and place	, and due to the o	ause(s) and r	nanner as s	stated.
	ne Ho n 24 t ne Fui	edical	(Check only 2 Medicel E	caminer: On the tand man	pasis of examination	ation and/or i	nvestigation, in my o					
	To the To the To the Comp	ž	29b. Signature and title of certifier	1			29c. Licens		2	29d. Date sign	·	
)	10/IVA		Nobersta	10 4.	Some	4		14865		rebrua	ary 1	9, 2004
	かんと		30. Name and address of person w Robustiano J	į.	-			orial Ave	enue, Cui	aberla	nd, Ml	D 21502
		ate trar	31. Date filed (Month, Day, Year) FEB 1 9 2	004 32/1	Registrar's Sign	ature	Sparks	/				

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State of Maryland	Department of H	ealth and Me	ental Hygiene	21	n	1

		•	For State Registrar	State of Ma	ryland / Dep	ertificate of	Death		giene (Reg. No.	2004	07638
			1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic	al .	Howard P. Hans						25,200		7:15 am M
	Examin	er	4a. Facility Name (If not institution, give		ma IIama		r Location of Dea	th		ounty of Deeth	
	Funeral		Manor Care Of Wheat 5. Social Security Number 6. Seg	7. Age	Ing HOME (In yrs. last birthda	Wheaton	If Under 24 Hrs	8. Date of Bir	th Vest	9. Birthp	plece (State or Foreign
	Director		579-12-2113	MM 2□F	88 Yrs.	Months Days	Hours Will	8. Date of Bir (Month, Da July 1	7, 191	5 Wash	ington, D.C.
	and w.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				1	10d. Inside City Limits
	Maryl. f sho	ţo	Maryland Montgome	erv	Silver S	Spring					XXYes 2□No
	r 28a	Director	10e. Street and Number	<u> </u>		10f. Zip Code			10g. Citize	n of What Cour	ntry?
	th wit	aiD	8750 Georgia Ave	nue #1510		20910				ed Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amount in the Medical Exam. In the Incition and once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:	o los	B. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No		Specify Yes or No rto Rican, etc.)		. Race - Americ Black, White, pecify: B1,	etc.
215-0036	72 hou	ted	15. Decedent's Edu (Specify only highest grade	cation e completed	16a. Dec	cedent's Usual Occup	pation during most of we	orkina		of Business/In	dustry
215	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	ve kind of work done . DO NOT use retire Lter	d)	9		lotel taurant	-
121	fled w flygier her th		12 17. Father's Name (First, Middle, Last)		wa.	rter	18. Mother's Na	ame (First, Middle			,
Maryland	nould be fited withir J. Mental Hygiene. narked other than natic event, Ite M.	o Be	Howard Hansbrough				Mary 1			,	
Z Z	should nd Men marks umaric	은	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Ma	iling Address (Street			er, City or T	own, State, Zip	Code)
	and 2 ealth a n 27 is		Betty Hansbrough	(wife)		Georgia					
Baltimore,	Pages 1.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State	1	position (Name of rematory or other pla eake Crema		Date /1/04		tion - City or To	
Balti	permit. I Departm Importal any inju		21. Signature of Funeral Service Scens			22. Name and Addre			ineral	Servi	ce 20012
			23a. Part1. Enter the discase, or compleshock, or heart failure. List only of	ications that caused	the death. Do not e						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pneumo							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):		3071			- 8	
	Lxammer	<u>.</u>	Sequentially list conditions,		.c Obstruc	ctive Pulm	onary Di	sease			
	nsit	nlne	Sequentially list conditions, ray beauty to mmediate cause. Enter Underlying Cause (Disease or injury			t Failure					
Ć.	icate be executed physician and s the burial-transit	edical Examiner	that initiated events resulting in death) Last		consequence of):	. C I GILLOI					
68760,	ate be nysicia he bu	cal		d							
	⊕ O a		IF FEMALE:	23c. If yes, outcome	of pregnancy				22	- Data of dala	
Вох	that the death certified by the attending of detached for use as	Physician/M	in the past 12_months?		2 Fetal death	B Ectopic pregnanc	у		23	d. Date of delive Month	Day Year
0	0 0 9	hysi	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9□ Unknown							
of Vital Records, P.	es gu	Completed by Pl	Part II. Other significant conditions co Diabetes	ntributing to death bu	at not resulting in the	underlying cause gr	ven in Part I.				he cause of death?
S	N D	iete	Hypertension					24a. Was	an	24b. Were auto	opsy findings available ompletion of cause of
Re	The lay	E O						auto perf 1 ☐ Yes	ormed?	death?	
ita		Be C	25. Was case referred to medical examiner?				112 112	eath (Check only			
∑ V	Physician: this certific ral director,	P	1 ☐ Yes 2 ☐XNo		nt 2 ER/Outpat	tent 3 DOA		Home 5 ☐ Res			(y)
ν	te lite	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year) 28b. Time Injur	y Wo	ry at irk?] Yes 2 ☐ No	28d. Describe	now injury o	occurrea	
Division	Attending r death. sctor: After by the fune	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ary - At home, farm,	street, factory, office				Number or Run	al Route Number,
Div	s after	Serti	4 Homicide	building, etc	:. (Specify)			City or 10	wn, State)		
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Certification:	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	rsician: To the best of iner: On the basis of and manner sta	examination and/or	eath occurred at the trining investigation, in my	ime, date and plac opinion, death oc	ce, and due to the curred at the time	cause(s) a date and p	nd manner as s lace, and due t	stated. o the cause(s)
	vithir To th comp	Me	29b. Signature and title of certifier	0			se number			signed (Month,	
	7		> June			D005	8962		Febr	uary 25	, 2004
	(30. Name and address of person who c				and the	tor Mr	2000	.2	
	- / C	210	Shashank G. Pate (Month, Day, Year)		2309 Sho:	refield Ro		acon, MD	2090	12	
	Regist	ate rar	EER 2.7.20		war B	Sport	2				

	•	For State Registrar	State of Maryland	Cer	tificate of D	Death	Re	g. No.	1004	0763
		Decedent's Name (First, Middle, Last)					2. Date of Deat		V	3. Time of Death
Physici		James Lawrence Har	rt				Month February	Day y 19,	2004	4:40 P M
/Medio		4a. Fecility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. Cos	inty of Death	
LAdiiii	161	Kline Hospice Hou			Mt. Airy			Fr	ederick	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,	Year)	9. Birthp	lace (Stete or Foreign
Director		215-52-9482	^{3M 2□ F} 56	Yrs.	Month's Days		Nov. 11.			inia
D D		Usual Residence of Decedent	1.0							0d, Inside City Limits
show		10a. State 10b. County	10c. City,	Town or Lo	cation					1 ☐ Yes 2 🛣 No
Ma B-f-	cto	Maryland Frederic	k F1	rederi	ck			_		
within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show Ita Marical Examinar must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Cour	itry?
th wi	ai	98 Blue Ridge Cour	t		21703				ISA	
eep .	iner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
afte or it	F	1 Never Married 2 Married	1 GYes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🙀 No	Specify:		Spi	ecify:	
urai',	d by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates: Vietn					ACL Kind	Whit	
72 h	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa kind of work done d DO NOT use retired;	uring most of work	ing	160. Kilia (of Business/In-	dustry
han ne	dm	Elementary/Secondary (0-12)	College (1-4or 5+)			,		0 1		
led v lygie her t		17, Father's Name (First, Middle, Last)	4	Cons	truction	18. Mother's Nam			usines	S
be find the pd of	Be		T						,	
12 should be filed within 7 h and Mental Hygiene 7 is marked other than "r raumatic event, Itle Mark	2	David Greenville 19a. Informant's Name/Relationship (T)		19b Mailir	no Address (Street a	Hallie	Grubb	City or To	wn State Zio	Code)
12 st h and 7 is n Iraur					•					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event. He Medical Example must be notified at once.		Lisa Marchanyvalen 20a. Method of Disposition	20b. Pla	ace of Dispo	ue Ridge		rederick Date	Mar 20c. Locati	yland on - City or To	wn, Stete
Yor in		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State Gate	metery crer	natory or other place eaven	θ)	Carlo		230	
mit. Pages partment of portant: If I y injury or	١.	* 4 □ Donation 5 □ Other (Specify)		C	emetery	Feb.	23,2004	Silve	r Spri	ng.MD
permit. Pages 1 ar Department of Hea Important: If Itam any injury or otha once.		21. Signature of Funeral Service Licens	1	Fr	2. Name and Addres ancis J.	Collins	Funeral	Home,	Inc.	
20 ≥ € α		23a. Pent. Enter the disease, or comp	HO		0 Univers	ity Blvd	.,W.,Sil	ver S	pring.	MD 20901
		23a. Pert1. Enter the disease, or composition shock, or heart failure. List only o	ne cause on each line.		-					Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	. Ai	fuite.	1 Immun	· Pericie	My Sin	disn	ne	4 YEAR
/Medical		resulting in death)	Due to (or as a consequ	_			,			
Examiner		Sequentially list conditions	b							
n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):					18	
ate be executed thysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c							
cate be exe		(esuming an death) Last	Due to (or as a consequ	ence or):						
ate he he	dicai		d							
leath certifica attending pt I for use as t	Mec	IF FEMALE:								
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1☐Live birth 2☐Fetal	death 3[Ectopic pregnancy			23d	Date of delivence Month	ory Day Year
the at	Sici	in the past 12 months? 1 □ Yes 200 No 9 □ Unknown	4☐Pregnant at time of de 9☐ Unknown	ath 5L	Other (specify)					
at the de i by the a stached	Phy			daine in about		an in Dort I	23a Did to	hacco use	contribute to t	ne cause of death?
es that igned b	b	Part II. Other significant conditions co	intributing to death but not resu	inting in the t	iliderlyllig cause give	sit iii t catt i.		es 2°MZÜN		ably 4 Unknow
w require been sig	Completed									
as be	pie						24a. Was a autops	SV	prior to co	psy findings available mpletion of cause of
The laste ha	E O						perform 1 ☐ Yes	med? 2 ⊠ No	death? 1 ☐ Yes	2 🗆 No
sician: The law requires to entificate has been signeriector, page 2 should be o	Be	25. Was case referred to medical				26. Place of Dea	th (Check only or	18)		
	To	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatie	nt 3 DOA Othe	er: 4 Nursing H	ome 5 Reside	ence 6	ther (Specif	y) Ituspice 1
l or Attending Physician: after death. Director: Atter this certifical in by the funeral director.	i.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury Work	at	28d. Describe h	ow injury o	ccurred	
Attending death. ctor: After y the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		,,		Yes 2 □No				
Atte ar de ecto by th	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (S City or Town	treet and N n, State)	lumber or Rura	il Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	Certification:									
To the Hospital within 24 hours a To the Funeral to completely filled		29a. Certifier 1 Certifying Phy	sicien: To the best of my knowner: On the basis of examinat	wledge, deal	h occurred at the time	ne, date and place	and due to the c	ause(s) an	d manner as s	tated.
n 24 n 24 or Fu	edical	(Check only 2 Medical Exam	and manner stated.	ion and/or in						
후문화상	ž	29b. Signature and title of certifier			29c. License	e number	2	9d. Date s	igned (Month,	Dey, Year)
To With	-	1	MD		D	-31912		2/	21/20	706
To To con	1									/
3+1		30. Name and address of person who o	completed cause of death (Item	23а) (Туре.	, Print)					
341		30. Name and address of person who of		23a) (Type	, Print)	uz, me	DEMILL	m	0 21	102

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 20, 2004 **Physician** 11:55P M T.F.A HERMAN /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. FEB. 3, 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign 6 Sax **Funeral** Months 1919 1 ☐ M 2 🖫 F WASHINGTON, DC 579-07-4751 85 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director SILVER SPRING MONTGOMERY MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23e or With 11504 OREBAUGH AVE 20902 UNITED STATES OF AMERICA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc filed within 72 hours after 1 ☐ Never Mamed 2 ☐ Married WHITE 1 ☐ Yes 2 No ŏ Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) JEWISH ORGANIZATIONS EXECUTIVE SECRETARY of Health and Mental Hygie fitem 27 is marked other t r other traumetic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) th and Mental H Be ٩ RUBEN GORDON ELKE SCHREIBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROCHELLE HERMAN - DAUGHTER 11504 OREBAUGH AVE., SILVER SPRING, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its eny injury or of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING DAVID MEMORIAL GARDEN 02/23/04 FALLS CHURCH, VA 21. Signature of Funeral Service Licenses DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 15 DAYS SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed tran resulting in death) Last Due to (or as a consequence of) attending physicien a for use as the burial Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CHRONIC RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page performed? certificate 1 Yes 2**X** No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours after To the Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 one 29d. Date signed (Month, Dey, Year) 29b. Signature and fitte of certifie 29c. License numbe FEBRUARY 21, 2004 D45660 10 30. Name and address of person who completed cause of death (from 23a) (Type, Print) 14300 GALLANT FOX LN., #124, BOWIE, MD 20715 DPINDER SINGH, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2004 Registrar Dacks

		-	1 - State Registrar	tate of Maryland / Dep <i>Ce</i>	artment of Healt	th and Mental I	Hygiene 2	004 07641
	Dhysiei		Decedent's Name (First, Middle, Last)			2. Date of Month	Day	3. Time of Death
į	Physicia /Medic	al	DAVID	HERSH	T (1 0) T		UARY 22,	
1	Examin	er	4a. Facility Name (If not institution, give stree		4b. City, Town, or Local CHEVY CHAS		4c. Count	GOMERY
			5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year If Ur			9. Birthplace (State or Foreign
	Funeral Director		067-01-6498 ¹⅓X™	2□ F 86 Yrs.	Months Days Hou	urs Min. JULY	Birth Pay, Year) 28, 1917	NEW YORK
_	2		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or L	ocation			10d. Inside City Limits
	shov	5	10a. State 10b. County MARYLAND MONTGOMERY					1 XYes 2 No
	the N	ect	10e. Street and Number	OHDVI O	10f. Zip Code		10g. Citizen of	What Country?
	3e or		5600 WISCONSIN AVENU	E. #704	20815		UNITED	STATES
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or liems 23e or 28e-f show other treametic event, the Modical Examiner must be notified at	Funeral Director	11 Marital Status 12.1		Was Decedent of Hispania If Yes, specify Cuban, Me	c Origin? (Specify Yes o	r No- 14. Ra	ce - American Indian,
စ္တ	or Ite	y Fu	1 Never Married 2 Married	I∏Yes 2 TXNo IfYes.Give		ecify:	- Speci	
21215-0036	hours turel',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education	Year or Dates:	edent's Usual Occupation		16b. Kind of E	Business/Industry
<u>.</u>	in 72 n "na	plet	(Specify only highest grade co.	moleted) (Give	e kind of work done during DO NOT use retired)	most of working		,
212	d with	Completed	Elementary/Secondary (0-12)	PAI	NTER		PAINTIN	G CONTRACTOR
2	al Hy	Be C	17. Father's Name (First, Middle, Last)			Mother's Name (First, Mi		
<u>yla</u>	ould b Ment Brked	ပ္	SAM HERSH				COLDENBER	
Maryland	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (Type,		ling Address (Street and N			
e,	Healt Healt		PAUL W. HERSH, SON 20a. Method of Disposition	20b, Place of Disp	37TH ST, N.	Date		City or Town, State
nor	ages ant of Mr. If it		1	oval from State	ematory or other place) ANON CEMETER	y 2/24/2004	ADELPH	I, MARYLAND
altimore,	permit. Pages Department of Himportent: If ite any injury or of once.		21. Signature of Funeral Service Licensee		22. Name and Address of F			
ä	Den any		Donald G. X	rollemus -	1170 ROCKVIL	LE PIKE, RO	CKVILLE.	ELS, INC MD 20852
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)	ons that caused the death. Do not er ause on each line. LUNG CANCER	nter the mode of dying, suc	th as cardiac or respirato	ry arrest,	Approximate Interval Between Onset and Death 9 MONTHS
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
		i e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events					
oʻ	an an		resulting in death) Last	Due to (or as a consequence of):				
8760,	ate be executed thysician and the burial-transit	lcal	d					
9		Physician/Medical	IF FEMALE: 230	If yes, outcome of pregnancy			22d D	ate of delivery
Вох	that the death certific ed by the attending p detached for use as	slan	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			onth Day Year
P.O.	the day the	Jysle	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown				
	requires that the been signed by th hould be detache	by Pr	Part II. Other significant conditions contrib		underlying cause given in I	Part I. 23e.	Did tobacco use cor	stribute to the cause of death?
rds	w require been sig should b	ed t	ARTERIOSCLEROTIC HE	EART DISEASE			1 X Yes 2 □ No	3 ☐ Probably 4 ☐ Unknown
of Vital Records,	aw as b	ompleted	CHRONIC OBSTRUCTIVE	PULMONARY DISEAS	SE		autopsy	Were autopsy findings available prior to completion of cause of
Ž	The late he	Com				1 🗆 Y	es 2 ANO	death? 1 Yes 2 No
/ita	ysicien: T	Be	25. Was case referred to medical examiner?	nital:		Place of Death (Check of		
of \	S 0 5	2	1 Tes 2 No	28a. Date of Injury 28b. Time		Nursing Home 5 X	Residence 6 🗆 Ot ribe how injury occu	
	ling After fune	tlon	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury				
Division	l or Attending after death. Director: Afte I in by the fune	ertification	2 Accident	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office		on (Street and Num r Town, State)	ber or Rural Route Number,
Ω	To the Hospitel or Al within 24 hours after or To the Funerel Direc completely filled in by	Ç	29a. Certifier 1 X Certifying Physici	an: To the best of my knowledge, dea	ath occurred at the time, da	ate and place, and due to	the cause(s) and m	anner as stated.
	e Hospitel 24 hours a e Funerel etely filled	edical	(Check only 2 Medical Examiner one)	On the basis of examination and/or and manner stated.	investigation, in my opinion	i, death occurred at the t	ime, date and place	, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of Certifier	1 1	29c. License num	nber	29d. Date sign	ed (Month, Day, Year)
	(Jan 4	thur	D138	18	FEBRUAR	Y 24, 2004
	18		30. Name and address person who comp	leted cause of death (Item 23a) (Type 5530 WISCONSIN AT	Print) VENUE, CHEVY	CHASE, MD	20815	
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 4 2004	32. Registrar's Signature	Sparks			

			1 - For State Registrar	State of	Marylar	nd / Depa	artmen rtificat	t of H	ealth a	and M		Reg. No		004	07	642
	Physici	an	Decedent's Name (First, Middle)		Elliot	t Hill					2. Date of De. Month	Da	y O	Year	3. Time o	of Death P M
	/Medic	cal	4a. Fecility Name (If not institution,				4b. City,	Town, or	Location of		Februa			2004 y of Death	7.41	
П	Examir	ier	Holy Cross Hosp				Sil-	ver :	Sprin	ıg		1	Mont	gome	ry	
	Funeral		5. Social Security Number		7. Age (In yrs.		If Under Months	1 Year_ Days	If Under Hours	Min.	8. Date of Bird (Month, Da	y, Year)			place (State	
f,	Director		579-82-8992 Usuel Residence of Decedent	142 111 201	3	3 Yrs.					July 20	, 19	/0	Washi	ngton	, D.C.
	yland 10w		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							1	0d. Inside C	
	89-fsh	ctor	Maryland Montg	omery		Silv	er Sp		3							2 ⊠ No
	vith th	Director	10e. Street and Number	D1 1 // 7			10f. Zip		0.00			-		What Cour	·	
	eath v	Funeral	2107 Belvedere	12. Was Dece	dent Ever in L	J.S. 13.	Was Dece		902 spanic Ori	gin? (Spe	cify Yes or No	_		State		
(0	ifter d	Ē	1 ☑ Never Married 2 ☐ Marri	Armed For ed 1 ☐ Yes	ces? 2⊠No						cify Yes or No Rican, etc.)			ick, White,		
21215-0036	ours a	d by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	e ites:		1 🗆 Yes		Specify:					<i>'y</i> : Whi		
15-(permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural; or Items 23e or 28e-f show minoriant: If Item 27 is marked other than "netural; or Items 23e or 28e-f show any other traumatic event, the Marical Examinant must be natified at once.	Completed	15. Decedent' (Specify only highes	s Education t grade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired	ation furing mos	t of worki	ng	16b. K	ind of E	Business/In	dustry	
12	withir iene. than	шо	Elementary/Secondary (0-12)	College (1	-4or 5+)		stant					Во	ok S	Store		
br	12 should be filed within "h and Mental Hygiene." F Is marked other than "traumatic event, the Mental Menta	BeC	17. Father's Name (First, Middle, I	_ast)					18. Mothe	er's Name	(First, Middle,	Maider	Suma	me)		
ylar	Menta Menta arked	10	Edward Elliott								th Latt					
Maryland	12 sh and n 7 Is m		19a. Informant's Name/Relationsh)	•				l Route Numbe					0.0
	1 and Health em 27		Elizabeth L. Hi 20a. Method of Disposition	11/Mother	20b.	D012 Place of Disponentery, creations				D	Drive,			- City or To		103
nor	Pages nent of l		1 ☐ Burial 2 ☑ Cremation '4 ☐ Donation 5 ☐ Other (Sp		otate	cemetery, cre ntgomery			1-	ebru. 200	ary 23,	Retl	1000	la Me	arylan	d
Baltimore,	permit. F Departme Importan any injur		21. Signature of Funeral Service I		TIOL						Funeral			Bethes	sda-Ch	evy
Ä	Depar Impor any ir		Kart	uc_	M00	198 75	57 Wis	scons	sin Av	ve., I	sethesd	a. M		0814 <u>–</u>	ase, I 3501	nc.
			23a. Pert1. Enter the disease, or shock, or heart failure. List	complications that co only one cause on e	aused the dea ach line.	th. Do not en	ter the mod	e of dyin	g, <i>suc</i> h as	cardiac o	r respiratory a	rrest,			Approxima Interval Be Onset and	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Aspi	ration	Pneum	onia								Sudder	
и	/Medical Examiner		resulting in death)		oras e conse rointe		B1 ee	dina	. IInr	ner					Sudder	1
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed execute.	D	or as a donew		DICC	u I I I E	, opp	701					badacı	
	outed Id ransit	Examiner	triat initiated events	Esop	hageal	Varic	es								Years	
Ö,	e exerian ar	EX	resulting in death) Last		oras a conse ititis										Years	
68760	cate b	dicai		d										-	Teals	
.O. Box 6	uires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2□Feta ant at time of	aldeath 30	⊒Ectopic pi ⊒ Other (sp							ate of delive		Year
Δ.	requires that the een signed by th nould be detache	þ	Part II. Other significant condition	ns contributing to de	eath but not re	sulting in the u	inderlying o	ause give	en in Part I			obacco Yes 2			he cause of bably 4 🕱	
Records,	> 0 70	Completed									24a. Was		24b.	Were auto	psy findings	available
R	The ate ha	E									perfo	rmed? 2⊠ No	,	death?	2 No	
Vital	cian: ertifica ector,	Be	25. Was case referred to medical examiner?	IIIhali				0.1	_	of Death	(Check only o	ne)				
of \	Physician: this certificant all director,	2	1 ☑ Yes 2 ☐ No 27. Manner of Death			ER/Outpatie			4 🗆 NU		ne 5 🗆 Resi				y)	
no	ding I After funer	tion	1 ⊠Natural 5 ☐ Pendin	9	of Injury h, Day Year)	Injury	м .	8c. Injun Worl	v? Yes 2□		ed. Describe	now inju	ly occu	1190		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place	of Injury - At h	nome, farm, st ify)	reet, factor				28f. Location (City or To			ber or Rura	al Route Nur	nber,
	e Hospita 24 hours e Funeral	Medical C	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physicien: To the Examiner: On the ba and mann	best of my kn asis of examin ner stated.	owledge, dea ation and/or in	th occurred evestigation	at the tin	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s date an	and m	nanner as s , and due to	tated. the cause(s)
	within To th	Me	29b. Signature and title of certifier	•			29		e number						Day, Year)	
	10		Juhr	ma M				D-3	2332			Feb	ruai	ry 21	, 2004	F
	, -		30 Name and address of person Suresh K. Gupta					e #2	20, 5	Silve	r Sprin	ng,	Mary	y1and	20902	<u> </u>
ı	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 23	2004 32. 8	egistrar's Sign	ature &	Sp	aks	/				-			

			1 - For State Registrar	State of Ma	aryland	l / Depa <i>Cei</i>	artmen rtificate	t of H	ealth a Death	and M		Reg. No.	2004			
	Physicia		Decedent's Name (First, Middle, Last) Irwin					Hornstein 2. Date of Dr. Month February					2 , 2004	3. Time of 2130	Death	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Casey House				4b. City, Town, or Location of Death Rockville					4c. County of Death Montgomery				
÷	Funeral Director			ex TM 2□ F	je (In yrs. la 8'		If Under Months	Days	If Under Hours	Min	8. Date of Bird (Month, Da January	v. Year	Co	plece (State of intry) York	or Foreign	
	Maryland	tor	Tod. State							10d. Inside Ci						
	be filed within 72 hou all Hygiene. I other then "natural other, the Medical E	I Direc	10e. Street and Number 3114 Gracefield Road, #401									_	. Citizen of What Country? Inited States			
980		by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		2 No Give XNo			Vas Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 No Specify:					o- 14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036		To Be Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	ed) (Give life.			dent's Usual Occupation skind of work done during most of work DO NOT use retired) ram Manager				16b. Kind of Business/Indu A.I.D.				
Maryland 2			17. Father's Name (First, Middle, Last Nathan				18. Mother's Nam Yetta				(First, Middle, Maiden Sumame)					
			19a. Informant's Name/Relationship (Charles Hornstein										Town, State, 2 and 207			
Baltimore,			20a. Method of Disposition 1 Burial 2 X Cremation 3 C 4 Donation 5 Other (Specie		ce	ace of Disponentery, createry, createry	matory or o	ther plac			ate 22/2004		ation - City or xandria		inia	
Balti			21. Signature of Funeral Service Lice	Byeva	A		Name ar Donalo	d V. Powde	Borg er Mi	wardt 11 Ro	Funer	al Ho tsvil	ome, P. Lle,Mar	A. yland 2 Approximat	20705	
	That the death certificate be executed with the attending physician and detached for use as the burial-transit	Completed by Physiclan/Medical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions b.									Interval Bet Onset and I	ween			
.O. Box 68760,			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as d	of pregnar	ncy death 3[□Ectopic p					2	3d. Date of del Month	-	Year	
<u>α</u>	og og								_	pacco use contribute to the cause of death? as 2 ⊋No 3 ☐ Probably 4 ☐ Unknown						
il Records,	ysician: The law is certificate has b director, page 2 sh									auto perfo	Was an autopsy performed? (es 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ∨ Yes 2 No					
f Vital		To Be	25. Was case referred to medical examiner?							Check only one) 3 5 ☐ Residence 6 ©Other (Specify) HOSPICE						
ion of	ng Ther	ledical Certification: T	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigate		28c. Injury at Work? M 1 Yes 2 No			28d. Describe how injury occurred								
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	Hospi 24 hour Funer letely fill		29a. Certifier (Check only one) Certifor Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Certifor Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Control of the cause(s) and manner as stated.									s)				
	To the vithin to the comp	Me	29b. Signature and title of certifier P. Like Mo				29c. License number D09470				29d. Date signed (Month, Day, Year) February 23, 2004					
-			30. Name and address of person who E.P. Libre, M.D.	10400 Co	nnecti	icut A		ensi	ngtor	Ma	ryland	2089	5			
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 4 2	JZ. megisi	trar's Signat	ture		nes		•						

IRWIN HORNSTEIN

	1 - State Registrar	State of Marylan	Cei	tificate of	Death		Reg. No.	2004	07644		
ysician	Decedent's Name (First, Middle, L. MARY MARGARE			2. Date of De	lary 20, 200		3. Time of Death				
Medical				U 63 T			1		12:10 PM		
aminer	4a. Fecility Name (If not institution, gi Shady Grove Adve			4b. City, Town, or Rockvil		tn		ounty of Deeth itgomery	7		
eral	5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir			olece (State or Foreign		
ctor	197-14-6185	1□M 2\(\text{\text{\$\text{\$\text{\$\text{\$}}}}\) 80	Yrs.	Months Days	Hours Min	8. Date of Bir Month, Da June 2	0,192	3 Penn	sylvania		
Be Completed by Funeral Director	Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits		
ō	Md. Montgo	mery Ga	ithers	burg					1X Yes 2 No		
Director								on of What Cou	ntry?		
aiD	19 Grantchester		2087	7	Unite	d State	es				
Funeral	11. Marital Status	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14	14. Race - American Indian, Black, White, etc.				
by Fi	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No Specity:			s	Specify: White			
	15. Decedent's 8	Education	16a. Deced	lent's Usual Occup		16b. Kind	6b. Kind of Business/Industry				
Completed	(Specify only highest gi	rade completed) College (1-4or 5+)		kind of work done of OO NOT use retired	during most of wo	orking					
Con	12		House	wite				Home			
Be	17. Father's Name (First, Middle, Las George Balog	t)			18. Mother's Na Anna S	me (First, Middle ZOVD	, Maiden S	umame)			
To Be	19a. Informant's Name/Relationship	(Type Print)	19h Mailie	g Address (Street a			er City or	Town State 7:-	(Code)		
	Margaret Grant (antchest							
	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place		Date		tion - City or To			
	1 ☐ Burial 2 🛣 Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec	_nemovarinom state Mot	ropoli	tan Crema		b. 21, 004	Alex	andria,	Va.		
	21. Signature of Fuperal Service Lice	nsee	22	. Name and Addres	ss of Facility De	Vol Fune	ral H	ome			
	10 East Deer Park Dr. Gaithersburg, Md. 20877										
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
	Immediate Cause (Final disease or condition resulting in death) a. Ischemic Colifis								l week		
		Due to (or as a consequ	uence of):								
Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a dansag	iente of):						· · · · · · · · · · · · · · · · · · ·		
Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
dical		d									
/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of delivery Month Day Year				
iciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown		Ectopic pregnancy Other (specify)							
Physician/Me	9 Unknown										
þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
Completed	Acote Kenal tail					1 Yes 2 No 3 Probably 4 Unknown					
mpie	Hypocalemia				24a. Was autor	utopsy prior to completion of cause					
							rmed? 2 X No	death?	2□ No		
o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🖟 No	Hospital:	EB/0	Othe	20	ath (Check only o		Tother (Co.			
—	1 Dignatient 2 Let Houtpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)										
atio	1 XNatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No										
Certification:	3 Suisido 6 Cauld not be							at and Number or Rural Route Number, State)			
	20 0 4	1				-					
edicai	29a. Certiflier (Check only one) 29a. C										
Med	29b. Signature and title of certifier					ld. Date signed (Month, Day, Year)					
	b de la			D006047				Feb 20, 2004 20850			
	30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print)	0 1 4		- /		•		
		Gen All I. I		1 Sec. / .	- 1 1 1 1 1	846					
	Eric J. Park 31. Date filed (Month, Day, Year)	990) Medical (32. Registrar's Signa	Centr	Dive	Kockville	CINA .	20850	>			

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 25

2004

racks

32. Registrar's Signature

Ryer

State of Maryland / Department of Health and Mental Hygiene 2001 07646 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death February 22, 2004 **Physician** FLORENCE LOIS 12:33P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Beltsville Prince George's 4411 Powder Mill Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, Year Jan. 18, 1927 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2√2 F 77 Alabama Yrs 252-32-3810 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show ir than "natural", or items 23a or 28a-f show the McCleal Examiner must be notified at 1 ☐ Yes 2 XNo Beltsville Completed by Funeral Director Maryland | Prince George's 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4411 Powder Mill Road 20705 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronic Assembler Medical Equipment permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygier
Important: If item 27 is marked other ti
eny injury or giner traumatic event, this 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Washington Singleton Mattie Mae Driggers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4411 Powder Mill Rd. Beltsville, Maryland 20705 Jesse M. Hurt -husband 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 2/25/2004 Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Funeral Service Licensee Donald 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma of lung /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): Box 68760, Certification; To Be Completed by Physician/Medical the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2√2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number parti O. Welten D23743 February 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin O. Weltz, M.D. 7525 Greenway Center Drive Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 26 2004 seppera Registrar

				State of Marylar	_				9	5 •
			1 - For State Registrar		-	cate of L			Reg. No. 20	04 07647
	Physici	an	1. Dacedent's Name (First, Middle, Las	0 //				2. Date of De Month		3. Time of Death
	/Medic	al	4a. Fecility Neme (If not institution, give) Hope	4b	City Tours of	Location of Dea	02	// 2.00 4c. County of E	
	Examin	er	Johns Hen Kins Bay view	_	. 1	Baltin		city	4c. County of E	7 0 0111
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) If	Under 1 Year onths Days	If Under 24 Hrs Hours Min	8. Date of Bit	th year) 9. 2, 1919 N	Birthplace (State or Foreign Country)
	Director		313-24-1433	□M 2XF 84	Yrs.	Jillis Days	TIOUTS IVIII	Sept 1	2, 1919 N	. Carolina
	land ow		Usuel Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location	on		-		10d. Inside City Limits
	Mary a-f sh	tor	DC N/A	Was	hington	, D.C.	•			1X Yes 2 □ No
	ous after death with the Maryland rat', or items 23a or 28a-f show Evan's er must be cotified at	Funeral Director	10e. Street and Number 1119 46th Plac	ce, S.E.	1	0f. Zip Code 2001)		10g. Citizen of Wha	•
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was	Decedent of Hi	spanic Origin? (S	Specify Yes or No no Rican, etc.)	14. Race - A	American Indian, Vhite, etc.
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give		Yes 2⊠ No		en litera		Black
21215-0036	within 72 hours after ene. than "natural", or ite	ed t	15. Decedent's Ed	Year or Dates:	16a. Decedent'	s Usual Occupa	ition	LSI	16b. Kind of Busine	ess/Industry
215	hin 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give kind life. DO N	VOT use retired,		orking		,
2	filed wit Hygien ther the	Completed	12			Superv			l	Government
and and	ntal H ad oth	Be	17. Father's Name (First, Middle, Last) Lawrence Scott					me <i>(First, Middle</i> . White	, Maiden Surname)	
Maryland	should sd Mer mark matic	2	19a. Informant's Name/Relationship (7		19b. Mailing Ad	dress (Street a			er, City or Town, Sta	te. Zin Code)
	s 1 and 2 should be filed within 72 hours aft I Health and Mental Hygiens Item 27 is marked other than "natural", or other traumatic avent, In Medical Evan		R. Yvette Sessor							D.C. 20019
altimore,	es 1 a of Hei fitem r othe		20a. Method of Disposition 11/2 Burial 2 Cremation 3		Place of Disposition	Name of	9)	Date	20c. Location - City	or Town, Stete
Ĕ	Pag ment ant: It		'4 Donation 5 Other (Specify	Ced	dar Hill		19 F	'eb 2004	Suitlan	d, MD
Ball	permit. Pages Department of Important: If it any injury or once.		21. Sign kg Funeral Service Licent	icenal)	133.	o H SUT	eet N.F	WDC	20002	Funeral Svc
		8	23a. Pert1. Enter the disease, or composition of heart failure. List only	lications that caused the deat ne cause on each line.	h. Do not enter th	e mode of dying	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
Ž.	Physician		Immediate Cause (Final disease or condition resulting in death)	a non Sma	11 cel1	lung	can	cer		months
B	/Medical Examiner		Tosuming in doaling	Due to (or as a consec	juence of):	1 1	can			non H.
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	mela.	5195	دے			months
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760,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consec	juence of);					
6876		dicai	•	d						
Box	nding use at	n/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome of pregn.					23d. Date of	delivery
P.O. B	The law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□Feta 4□Pregnant at time of c 9□Unknown		opic pregnancy ser (specify)			Month	Day Year
α, σ	ss that gned to be deta	by PI	Part II. Other significant conditions co	ontributing to death but not res	sulting in the under	ying cause give	in in Part I.			te to the cause of death?
ord	w requires that been signed should be det	ted						1 🖼	¶es 2□No 3□	Probably 4 Unknown
ec	has begge 2 sh	Completed						24a. Was auto	osv prior	autopsy findings available to completion of cause of
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₹	s certil	o Be	25. Was case referred to medical examiner? 1 Yes 2 140	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Othe		ath (Check only	one) dence 6 🗆 Other (5	Specific
J Of	Attending Physician: r death. sctor: After this certific by the funeral director.	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at		how injury occurred	sp a city)
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Division of Vital Records,	Prospital or Attenc 24 hours after death Funeral Director: etely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	281. Location (City or To		r Rural Route Number,				
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai (29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my knowing of the basis of examination and manner stated.	owledge, death occurrence ation and/or investigation	curred at the time gation, in my op	e, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1		29c. License	- 1/		29d. Date signed (M	
0	72		Muhle F Bells	nlow, mo		DSS	3/6		02-1	11-2004
K	(5)		michele F. Bellan	completed cause of death (Iter	n 23a) (Type, Print	s Baye	ie Cine	le Balt	more me	11-2004
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 9 2004	34. Hegistrar's Signi	ature	•				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygieney 07648 Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 HUNSECKER March 4:35 P. M MART /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Beverly Healthcare Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Sept. 18 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1970 1□M 200F Penna. 197-58-2976 33 Vrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "netural", or Items 23a or 28e-f show the Medical Examinar must be motified at 1 ☐ Yes 2 No Director Penna. Franklin Greencastle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3243 Williamson Rd. 17225 U.S.A. death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 💢 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Importent: If item 27 is marked other the any injury or other treumatic event, Ittel, once. 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be June E. Timmons Clifford E. Lehman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daryl E. Hunsecker/Husband 3243 Williamson Rd. Greencastle, Pa. 17225 20b. Place of Disposition (Name of cometery, crematory or other place)
Mercersburg Mennonite
Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mercersburg, Pa. * 4 ☐ Donation 5 ☐ Other (Specify) 3/9/04 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc. 21. Signature of Funeral Service Licensee 45 S. Carlisle St. Greencastle, Pa. 17225 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) GLIO BLASTOMIA Priysician 14 Month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 KNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No of or Attending Physicien: after death. Director: After this certifica To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mayen D28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stral Hagestein M 368 mille 31. Date filed (Month, Day, Year) MAR 1 1 2004 32. Régistrar's Signature State Registrar

	3		1 - For Registrar	State o	f Mary	land / Dep <i>Ce</i>	artmen rtificat					giene Reg. No. 2 (004	07649	
	Physici /Medio	al	Decedent's Name (First, Middle, La Gloria Lo Gloria Lo 4a. Facility Name (If not institution, gir	is Hal			Ah City	Town or	Location	of Death	2. Date of Dea Month March	Day	O 4	3. Time of Death 11:00 Рм	
	Examin	er	1316 Stablers	sville	Road] yrs. last birthday	Pa	arkt			8. Date of Birt	Bal	imo:	re	
	Funeral Director		213-38-5692 Usual Residence of Decedent	1 □ M 2 (ŽAF	78	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Pa) May 26	1925	Coul	place (State or Foreign ntry) Unknown	
	a-f show	ctor	MD Balti:	more	10	c. City, Town or L Parkto							10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
	th with th	ai Director	10e. Street and Number 1316 Stablers	sville	Road	Ē	10f. Zip	120				ntry?			
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gir Year or D	orces? 2[XNo ve	If Yes, specif			ispanic Ori in, Mexical Specify:		ecify Yes or No- Rican, etc.)	14. Rad Bla Specif	ck, White,	can Indian, etc. nite	
21215-0036	i within 72 ho jiene. r than "natur the Medical I	Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired ache	during mos I)	t of work	ing	16b. Kind of B			
Maryland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Las George Hale						Al	ice	e (First, Middle, Turnb	augh			
	and 2 sh relth and 127 is m ar treum		19a. Informant's Name/Relationship Myron Hale/Bro			131	6 St	able	ersv		Rd.,	Parkto	on,M	D 21120	
Baltimore,	Pages 1 ment of He ant: If iten jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	fy)	State S	ob. Place of Disp complety, cre Stabler Methodis	: Ceme	ter	y	Marc 200		20c. Location Parkt	on, N	MD	
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	Wedical Medical Prize Pr	Examiner	23a. Part1. Enter the disease, or conshock, ok-heart failure. List of the shock of	a. Due to c.	oach line. Lor as a co	ons quence of):	care	lin	Ring	Jare	- from	igst,		Approximate Interval Batween Onset and Death	
.O. Box 68760,	death certifica e ettending ph d for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		oirth 2 🗀 nant at time	Fetal death 3	⊒Ectopic pr □ Other (sp						ite of delive	ery Day Year	
ds, P	uires that n signed t	b	Part II. Other significant conditions	contributing to d	eath but no	ot resulting in the	anderlying o	ause give	en in Part I					he cause of death?	
Vital Record	The law requires that the sete hes been signed by the page 2 should be detache	Completed	Ostevarth	ritis	0	0	0				24a. Was autop perfor 1 🗆 Yes	med?	Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of	
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Division of	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificete hes completely illed in by the funeral director, page 2	Certification;	27. Manner of Seath 1 = atural 5 Pending investigation 3 Suicide 6 Could not determine	e 28e. Place	of Injury -	· At home, farm, s	М		/at <br Yes 2□	No		Street and Numb		al Route Number,	
ρį	lospitei or I hours after unerat Dire	edical Certl	29a. Certifier 1 Certifying P	hysician: To the		Specify) y knowledge, dea amination and/or in						cause(s) and ma			
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medi	29b. Signature and title of certifier		ner stated				number			29d. Date signe			
,	12		30. Name and address of person who	completed cau	se of death	(Item 23a) (Type	Print)	1	Rd.	Par	Kton	M/)	211	20	
d	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 1 20	4	egistrar's	Signature	do	rels)	, - (,	1210.07		7 🖦		

RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	. FOI	partment of Health and Mental ertificate of Death	Hygiene Reg. No. 2004 07650
	Decedent's Name (First, Middle, Last)		of Death 3. Time of Death
Physician /Medical	Norman Lee Henderson, Jr.	Mont FEBR	Day Year JARY 10, 2004 2:40P.
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	2311 SETON WAY	FORESTVILLE	PRINCE GEORGES
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	Months Days Hours Min. (Mont	h, Day, Year) Country)
Director	213-04-1162	Feb.	7, 1982 Washington, DC.
land ow	10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
Many First tor	Maryland Prince George Foresty:	ille	1 v Yes 2 No
with the Mar or 28a-f ∎ be notified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
th with with and 23a c	2311 Seton Way	20747	United States
frer death v	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	or No- 14. Race - American Indian, black, White, etc.
JSO arts after the second of t	1 ☑ Never Married 2 ☑ Marned 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2፟፟፟ No Specify:	Specify: Black
		cedent's Usual Occupation	16b. Kind of Business/Industry
A I A I D-U	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working a. DO NOT use retired)	
d with giene ir the tree tree tree tree tree tree tree	12 3 S	tudent	Education
DG file by file by othe	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	
Viand Suid be fit Mental H Mental H arked oth arked oth TO Be		Louise Lang	ston
lore, Maryla ges 1 and 2 should t of Health and Men If item 27 is marke or other traumatic		ailing Address (Street and Number or Rural Route N	
C, R l and lealth lealth her t		1 Seton Way, Forestville	e, MD. 20747 20c. Location - City or Town, State
in it is a series of the serie	1 X Burial 2 Cremation 3 Removal from State	rematory or other place)	
DESILITION Permit. Pages Department of Important: If it inty injury or o		Memorial Park2/14/2004 22. Name and Address of Facility Pope Fi	Landover, MD.
Daltimore, Mi permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra once.	21. Signature of Funeral Service Licensee	5538 Ma	uneral Homes arlboro Pike ville, MD. 20747
THE REAL PROPERTY.	23a. Pert1. Enter the diseas, o complications that caused the lath. Do not shock, or heart failure, List only one cause on each line.	FOTESLY enter the mode of dying, such as cardiac or respirat	ville, MD. 20747 ory arrest, Approximate
	shock, or heart failure, List only one cause on each line. Immediate Cause (Final	-1-1 way of 57.10	Interval Between Onset and Death
Physician / /Medical	disease or condition resulting in death) a. ON + act quit Due to (or as a consequence of):	ishot wound of the	e keuch
Examiner			
	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying b. Due to (or as a consequence of):		
executed and ial-transit	Cause (Disease or injury that initiated events c.		
e exe			
Geath certificate be executed death certificate be executed at for use as the burial-transit clean/Medical Examir	d		
Medification of the control of the c	IF FEMALE: 23c. If yes, outcome of pregnancy		2010/01/16
T.C. BOX of the death certification of the attending of the attending of the asserted for use as physician/Mer	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
. 0 00 -	1 Yes 2 No 9 Unknown	o El Grido (opociny)	
		e underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
tuires the signer of the signe			1 Yes 2 Kno 3 Probably 4 Unknown
2 2 0		24a.	Was an 24b. Were autopsy findings available
The lav		112	autopsy prior to completion of cause of death? Yes 2 \(\subseteq \text{No} \) 1 \(\subseteq \text{ZYes} \(2 \subseteq \text{No} \)
	25. Was case referred to medical	26. Place of Death (Check	
_ % s 5	1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpa	tient 3 DOA Other: 4 Nursing Home 5	Residence 6XIOther (Specify SCENE
ding Phy h. After this funeral d		y Work?	cribe how injury occurred
UNISION Tor Attending after death. Director: After S in by the funer	2 ☐ Accident investigation 2 ─ 1 C − 0 4 1 H :- 3 ★ Suicide 6 ☐ Could not be		eased shot self
UIVISION of tall or Attending P is after death. al Director: After tall in by the funeral contribution:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	City	tion (Street and Number or Rural Route Number, or Town, State) 2311 Seton Way
Hospital or the hours after Funeral Dittely filled in the hours after the hour		tores	stville, RG. Co. MD,
Hos Fur Tely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	r investigation, in my opinion, death occurred at the	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)
within 2 To the complet		29c. License number	29d. Date signed (Month, Day, Year)
+ 3 + ŏ	1 × 1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	O.C.M.E.	FEBRUARY 11,2004
(3)	30. Name and address of person who completed cause of death (Item 23a) (Ty		IEDROAMI II,2004
	S. R. HOGAN	111 Penn Street, Balti	more, Maryland 21201
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Registrar	FEB 1 7 2004 See Figure 1 State of Stat		

DHMH 17 Rev 1/2001

Please

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Sta	e or Print in Black Indelible Ink. Ensure All Co ate of Maryland / Department of Health and Menta	al Hygiene 2004	076
	Certificate of Death	Reg. No.	_

51

3. Time of Death

10d. Inside City Limits

1 Yes 2 No

0035 AM

For Stata Registra 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ANTOINE HENRY FEBRUARY 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTEDMERY OLNEY MONTGOMERY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 10 M 2□F Odays Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exaction for most be rectified at aging or other traumatic event, the Medical Exaction for most be rectified at aging or other traumatic event, the Medical Exaction for the profiled at aging or other traumatic event. 10a. State 10b. County 10c. City, Town or Location SILVER SPRING MONTGOMERY Funeral Director MARYLAND 10f. Zip Code 10e. Street and Num 10g. Citizen of What Country? 20906 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status I ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ Todae lad 19a. Informant's Name/Rel tis ship (Type, Print) 19b. Mailing Address (Stree MOTHER 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ★ Other (Specify) 21. Signature of Funeral Service Licensee and Address of Facility Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

been signed by the should be detached completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

shock, or heart failure. List of	complications that caused the death. Do not enter the mode of dying, such as cardiac or respira only one caus, on each line.	atory arrest, Approximate Interval Between Onset and Death									
Immediate Cause (Final disease or condition resulting in death)	disease or condition										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of): d.	Membras									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year									

Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consect	quence of):	Ryphill	of Mar	Neraca							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Year										
Part II. Other significant conditions o	ontributing to death but not re	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?							
				24a. Was an autopsy performed								
25. Was case referred to medical examiner?	26. Place of Death (Check only one)											
1 Yes 20 No	Hospital: Inpatient 2	☐ ER/Outpatient 3☐	Home 5 TResidence	dence 6 Other (Specify)								
27. Manner of Deall Statural 5 Pending Pending		28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At to building, etc. (Spec	nome, farm, street, factify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	citian: To the best of my knowledge, death occurred at the time, date and place, and due to the causer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.										
29b. Signature and title of certifier	77		29c. License number	29d.	Date signed (Month, Day, Year)							

and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tit

of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar

31. Date filed (Mon

within 24 hours after death To the Funeral Director:

Please Type or Print in Black Indelible Ink. Assure Ail Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) THEODORE HUNDLEY, JR. 4b. City, Town, or Location of Deeth 4c County of Death 4e Facility-Name (If not institution, give street and number) 6 eoge's Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1∏M 2□ F 229-52-4684 VIRGINIA Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State UPPER MARLBORO PRINCE GEORGE'S MARYLAND M☐ Yes 2 ☐ No 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 20774 USA 14017 GADSEN COURT 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Howard University Graphic Artist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Theodore Hundley, Sr. Ruth Edmonds 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14017 Gadsen Court Upper Marlboro, MD 20774 Estelle Berry Hundley /wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Grand View Memorial Park 2-24-04 Rock Hill, S.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Marshall's Funeral Home of MD 21. Signature of Funeral Service Licenses WCOULUM 4308 Suitland Road Suitland, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. oproximate nterval Between Onset and Death Drubetes with Conflication Immediate Ceuse (Final disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypo thyroid Isn 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

Examiner Examine or Attending Physician: The law raquires that the death cartificate be executed Division of Vital Records, P.O. Box 68760, Director: A filled in by within 24 hours a
To the Funeral C

Physician

/Medical

Examiner

Funeral Director

څ

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryk nent of Heelth and Mantel Hygiens and the Heelth and Markel Hygiens "naturel", or items 23e or 28e-f sho wit: If them 27 is marked other than "naturel", or items 23e or 28e-f sho wit of the world be notified a ury or other traumatic event, the Medical Evanther must be notified a

Depertment of important: If it any injury or o

Physician

/Medical

Baltimore, Maryland 21215-0020

Physician/Medicai Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed Be 25. Was case referred to medical examiner? ို 1 Yes 2 No 28c. Injury et Work? 27. Menner of Death Certification: 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

State

3001 Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Dete filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

2. Registrer's Signature

Registrar

22 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

(ebrum 18, 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2001 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:07 AM William February 16,2004 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Eacility Name (If not institution, give street end number, Examiner BALTINORE Ltimore AMEdICAL If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Days Min. 1 😡 M 2 🗆 F Months Hours 53 Director 578-68-5650 July 2, 1950 Washington, D.C Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalith and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No MD Director Harford Aberdeen 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21001 31 E Blair Avenue #2 USA Funeral 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Yes 2 □ No If Yes, Give 1971-1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 No Specify: ۾ 3 Widowed 4 Divorced 1974 Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Disabled VEteran 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Barbara Ashley William F. Hall, Sr. 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 2358 Hazelwood Ct. Waldorf, Md. 20601 Monique Randolph Daughter 20b. Place of Disposition (Name of cemetery, crematory or other p Dete 20c. Location - City or Town, State 20a. Method of Disposition Arlington National 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 2-27-04 Arlington, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MArshall's Funeral Home 21, Signature of Funeral Service Licenses 4217 9th. St. N.W. Washington, D.C. 20011 Marsha 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Dheumonia Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 L Y 35 8 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Dey 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Naturel 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte complately filled in by the fun investigetion 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 10 NO Leene Street Bactimore Panchal 31. Dete filed (Month, Day, Year) Registrer's Signature State FEB 2 4 2004 Registrar

DHMH 16 Rev 6/95

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital Medical State Registrar

Ni. LING LI. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

29c. License number O.C.M.E.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) February 29, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

2. Registrar's Signature

MAR 0 5 2004

Phy	ysi	cian
/N	lec	dical
Ex	am	iner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Items 23s or 28s-1 show any injury go other traumatic avant, the Medical Extra trained to notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4a. Facility Name (If not institution, give street and number) 8315 WOODMOOR BLVD. 5. Social Security Number none 1 M 2 F 43 Vrs. 4b. City, Town, or Location of Death BETHESDA 4c. County of Death MONTCOMERY 4c. County of Death MONTCOMERY 9. Birthpiace (State of Country) Months Days Hours Min. 7/11/1960 Guatema. 10a. State 10b. County 10c. City, Town or Location	Death										
4a. Facility Name (If not institution, give street and number) 8315 WOODMOOR BLVD. 5. Social Security Number none 1 M 2 F 43 Yrs. 4b. City, Town, or Location of Death BETHESDA 4c. County of Death MONTGOMERY 4c. County of Death MONTGOMERY 4d. County of Death MONTGOMERY 4c. County of Death MONTGOMERY 4c. County of Death MONTGOMERY 4d. County of Death MONTGOMERY											
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Hours Hours Nin. 9. Birthplace (State of Country) Guatema. 9. Birthplace (State of Country) Guatema. 10a. State 10b. County 10c. City, Town or Location 10d. Inside C											
10a. State 10b. County 10c. City, Town or Location 10d. Inside C											
MD Prince George's Hyattsville											
10e. Street and Number 1411 Kanawha St. Apt.302 10f. Zip Code 20783 10g. Citizen of What Country? Guatemala											
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.											
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)											
Laborer Construction 17. Father's Name (First, Middle, Last) Pablo Vasquez Laborer Construction 18. Mother's Name (First, Middle, Maiden Sumame) Emilia Izara											
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 Gabriel Romero/Brother-in-law 8004 14th Avenue #202 Hyattsville, Md											
20a. Method of Disposition 1 \(\times \) Burial 2 \(\times \) Cremation 3 \(\times \) Removal from State (amount of the place) Seneral de San Juan 3/04/04 Ostuncalco, Guate (amount of the place) Seneral de San Juan 3/04/04 Ostuncalco, Guate (amount of the place) Seneral de San Juan 3/04/04 Ostuncalco, Guate (amount of the place) Seneral de San Juan 3/04/04 Ostuncalco, Guate (amount of the place) Seneral de San Juan 3/04/04 Ostuncalco, Guate (amount of the place) Seneral de San Juan 3/04/04 Ostuncalco, Guate (amount of the place) Seneral de San Juan 3/04/04 Ostuncalco, Guate (amount of the place) Seneral de San Juan 3/04/04 Ostuncalco, Guate (amount of the place) Seneral de San Juan 3/04/04 Ostuncalco, Guate (amount of the place) Seneral de San Juan Seneral de Seneral de San Juan Seneral de Sene	cema										
21. Signature of Funeral Service Licenses PHILIP D. RINALDI FUNERAL SERVICE, P. A 9241 Columbia Blvd. Silver Spring, Md2	0910										
23a. Part1. Enter lie disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ### AD INTIVITIES Due to (or as a consequence of):	ween										
Sequentially list conditions, any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.											
IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	Year										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of contribute to t											
24a. Was an autopsy performed? death? 12 Yes 2 No 1 2 No 1 2 No	available ause of										
25. Was case referred to medical saxminer? 15. Was case referred to medical saxminer? 15. Was case referred to medical saxminer? 16. Place of Death (Check only one) 17. Other: 4. Nursing Home 5. Residence & XIXOther (Specify) AT S	CENE										
27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of Linjury at Work? 28c. Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred 4 Natural 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Num City or Town, State) 29a. Certifier (Check only one) 28d. Describe how injury occurred 4 IT ON HEAD BY BRILLS WORT ON STRUCT ON S 28f. Location (Street and Number or Rural Route Num City or Town, State) 28f. Location (Street and Number or Rural Route Num City or Town, State) 29a. Certifier (Check only one) 29a. Certifier 29a. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 28d. Describe how injury occurred HIT ON HEAD BY BRILLS WORT ON S 28d. Describe how injury occurred HIT ON HEAD BY BRILLS WORT ON S 28d. Describe how injury occurred HIT ON HEAD BY BRILLS WORT ON S 28d. Describe how injury occurred HIT ON HEAD BY BRILLS WORT ON S 28d. Describe how injury occurred HIT ON HEAD BY BRILLS WORT ON S 28d. Describe how injury occurred HIT ON HEAD BY BRILLS WORT ON S 28d. Describe how injury occurred HIT ON HEAD BY BRILLS WHITE AT CONSTRUCT ON S 28d. Describe how injury occurred HIT ON HEAD BY BRILLS WORT ON HEAD BY BRILLS	ITE										
286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 287. Cartifier 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 288. Place of Injury - At home, farm, street, factory, office City or Town, State) 83 Succide 4 Homicide 286. Location (Street and Number or Rural Route Num City or Town, State) 83 Succide 4 Homicide 287. Location (Street and Number or Rural Route Num City or Town, State) 83 Succide 4 Homicide 288. Place of Injury - At home, farm, street, factory, office City or Town, State) 83 Succide 4 Homicide 288. Place of Injury - At home, farm, street, factory, office City or Town, State) 83 Succide 4 Homicide 289. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29a. Certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29c. License number (Check only one) 29b. Signature and title of certifier (Check only one)	s)										
29b. Signature and titla of certifier O.C.M.E 29c. License number O.C.M.E FEB. 25, 2004											

State

Registrar

31. Date filed (Month, Day, Year)

FEB 27 2004

Sparker

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician VIOLA M. JOHNSON 7:00 PM FEB 2004 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CARROLL WESTMINSTER 2271 HUGHES SHOP RD. | Honder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | 12/16/1923 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral MARYLAND 1 □ M 212 F 80 Yrs 219-12-4339 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28e-f show other treumetic event, the Medical Exercit er must be notified at 1 ☐ Yes 2 No WESTMINSTER CARROLL MD. Direct 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ŏ 21158 USA 2271 HUGHES SHOP RD. or items 23a Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE è 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER HOUSEWIFE 10 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tiem 27 is marked oth any jiury or other treumetic event 2008. Be VIOLA E. LE BON WALTER S. YOUNG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2271 HUGHES SHOP RD., WESTMINSTER, MD. 21158 CLARENCE JOHNSON -HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State PLEASANT VALLEY CEM. 2/24/04 PLEASANT VALLEY, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Fignature of Funeral Sen 254 E. MAIN ST., WESTMINSTER, MD. 21157 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cadse on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Pnysician estive Month 6V19 /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physicien: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence Box 68760. Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dec 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2. No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2≧No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 【 Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 PER/Outpatient 3 DOA nours after death.
nerel Director: After this
filled in by the funeral di 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WIL Balfimuse Blud westminster Balfimuse Blud mD 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 VAYWAZA 1130 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Wilma Charlene Jones February 13, 2004 5:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Heartlands of Severna Park Severna Park Anne Arundel 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□M 2□F Yrs 77 446-20-3385 Director Feb. 26, 1926 Oklahoma Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County d other than "natural", or Items 23a or 28a-f show event, the Medical Exempler must be notified at 1 ☐ Yes 2 ☑ No Anne Arundel Severna Park Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 199 Topeq Drive 21146 USA death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ₩ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 of Health and Mental Hygi item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be fill and Mental H Be Charles Williams Audrey Evans 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum 2002. Nancy Goetschius/Daughter 199 Topeg Drive Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □Cremation 3 □Removal from State February 25 Arlington National Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2004 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home comes Severna Park, MD 21146 5. Enter the disease, or priplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2. Patr . Enter the disease, or Join ediate Cause (Final disease or condition Myocara Physician /Medical resulting in death) Due to (or as a consequence of): **Examiner** Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician ar s the burial to Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month į Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 Denknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy page perform certificate 1 🗌 Yes 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical 455, 8tec 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Wher (Specify) Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signatuge and title of certifier 29c. License number 0725 cause of death (Item 23a) (Type, Print) eransthuy Millersville MD21108 8601 31. Date filed (Month 32 Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene	1	11	1
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07659 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 7:56 p.m. George Spencer Johnson February 18, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 26600 Morganza Turner Road St. Mary's Mechanicsville If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Yrs. Maryland Director 219-34-0494 71 Feb.22,1932 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23s or 28s-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Mechanicsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 26600 Morganza Turner Road 20659 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natures" any injury or other transmitted. Yes 2□No1951 -1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo À If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 Divorced 1954 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Propane Gas Technician Propane Gas 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Francis Vernon Johnson Annie Myrtle Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diane A. Johnson / Daughter 24868 Three Notch Road, Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2-23-2004 4 Donation 5 Other (Specify) St. Joseph's Morganza, Maryland eral Pensee 21. Sig 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CA.2 d **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown t signed by the Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Deen fel Lvz 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No this certificate has autopsy performed? 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide after To the Hospital of within 24 hours at To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 014285 Trong 30. Name and address of person who complet -cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year)

32. Registar's Signature

FER 2 0 2004 31. Date filed (Month, Day, Year) State Registrar

			1 - State State Registrar	of Maryland	/ Depa	artment <i>tificate</i>	of H	ealth a	ind M	lental Hyg	jiene _{eg. No.} 2 (004	076	560
1	Physici		1. Decedent's Name (First, Middle, Last) Alberta Lorraine JOHN	SON						2. Date of Dea Month Feb. 17	Day	Year	3. Time of 2100	Death M
	/Medic Examir		4a. Facility Name (If not institution, give street and 20526 Lehmans Mill Ro	number)			Hag	Location o	own	reb. 17	4c. Cour	ty of Death shing		
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Oct. 24	Year) ,1938		plece (State of ntry) cyland	r Foreign
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	be filed within 72 hours after death with the Maryland that Hyglene. do other then "natural", or Items 23e or 28e-f show event, I're Medical Examiner must be notified at	Director	10e. Street and Number 20526 Lehmans Mill Ro	ad		10f. Zip		742		1	0g. Citizen o	What Cou	ntry?	
36		by Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes.	ecedent Ever in U.S. Forces? is 2 🖾 No		Vas Decede Yes, speci	ent of His ify Cuban	spanic Orig n, Mexican,	jin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14. R	14. Race - American Indian, Black, White, etc. Specify: white		
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Mary	12 should to h and Ment 7 is marked traumatice		19a. Informant's Name/Relationship (Type, Print) Blaine Thomas, Sr s			_				Route Number			-	
Baltimore, I	Pages 1 and 2 should nent of Health and Men int: If item 27 is marke iry or other traumatic	1524	20a. Method of Disposition 1 🛣 Burial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify)	20b. Place	e of Dispos etery, crem	sition (Name natory or oth n Mem	e of her place)	D	ate	20c. Location	- City or T		and
Baltii	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral-Service Licensee	22.	. Name and	Address	of Facility	,		CH FU	NERAL	HOME		
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ن	HU		30. Name and address of person who completed or	use of death (Item 23	a) (Type, F	erint)	mpie	RL.	Hay	exten.	NA	201	2	
30. Name includences of person with completed cause of death (term 23) (type, Print) They Do Harris 16110 Medital Campus Rd. Haijenton, MA 21772 State Registrar 31. Date filed (Month), Par Year), 9 2004 32. Registrar's Signature Registrar														

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 07661
ı	Physici	an	1. Decedent's Name (First, Middle, Last) Robert Nelson Jessee 2. Date of Death Month Day Yeer 12:05 P M
7	/Medic Examin	_	Ha. Facility Name (If not institution, give street and number) Washington County Hospital 4b. City, Town, or Location of Death Hagerstown, 4c. County of Deeth Washington
	Funeral Director		5. Social Security Number 231-30-9421 6. Sex 12M 2 F 73 Yrs. 73 Yrs. 73 Yrs. 8. Days Hours Min. 7. Age (In yrs. last birthday) Hours Min. 7. Age (In yrs. last birthday) Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 24, 1930 VA
	ow ow		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any njury or other traumatic event, the Medical Exacilinal mail the Excilinal at Ance.	Director	MD Washington Big Pool 1 □Yes 2XINo 10e. Street and Number 10f. Zip Code—1 1 10g. Citizen of What Country?
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Man	od 2 sho lith and i 27 is ma		19a. Informant's Name/Relationship (Type, Print) Ada I. Jessee wife 12933 Keefer Rd. Big Pool, MD 21711
Baltimore,	Pages 1 ar nent of Hea ant: If item: ary or other		20a. Method of Disposition 1 Removal from State 20b. Place of Disposition (Name of cerugetry, crematory or other place) 1 Removal from State 20c. Location - City or Town, State Cedar Lawn Cem. 20b. Place of Disposition (Name of cerugetry, crematory or other place) Cedar Lawn Cem. 20c. Location - City or Town, State Hagerstown, MD
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68760,	Physician by Sician and Sician and Sician and Sician and Sician and Sician site Portion 1997	dical Examiner	23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
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7	45		D.28365 2 17-04 30. Name and address of person who completed cause of death (It im 23a) (Type, Print). MAN 2AR. D SHAFI. 368 mill Street Nagersterm MD 21740
			MANZAR. DSHAFI. 368 null Street- Hagerstown MD21740 31. Date filed (Month, Day, Year) 32. Registrar's Signature
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Divis	o afte	Certification:	3 Suicide 6 Could no 4 Homicide determin	280. Place of in	jury - At hor tc. (Specify)	ury - At home, larm, street, lactory, office 281.						28l. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel or within 24 hours after To the Funeral Dircompletely filled in	edical C	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of my know of examinati lated.	vledge, deat on and/or in	h occurred ivestigation	at the tim	ne, date ar pinion, dea	nd place, ith occurr	and due to the red at the time,	cause date a	(s) and manner nd place, and d	as sta ue to	ted. the cause(s)	
	To th To th compl	Me	29b. Signature and title of certifier	1 ()			29	c. License	e number			29d. C	Date signed (Mo	nth, D	lay, Year)	
	20		1 Kom Hy	1 ChX	MI	1		046	706 (GA)		D	225	Ö	4	
e	20		30. Name and address of person w	completed cause of	death (Item	23a) (Type,	, Print)								L CENTER	
			KENNETH J. ORT		IC US					BE	THESDA	MD	20889-	560	0	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2.7		rar's Signat	La La	Sp	acks								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 07663 1- State Registrar/AMEND#20b, operFH2/24/04, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 **Physician** 2.10P.M JR. 04 ames hur /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Mary land Clinton, MATIANA Southern HOSPITal (eorge If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1₽M 2□F Days Months Hours 250-03-695 South Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 snouns on more.

Department of Health and Mental Hygiene.

Importent: If Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow importent: If Item 27 is marked other than "natural", or Item 23a or 28a-f ahow inclury or other traumatic avent, the Madical Examiner must be nutilised at 1 Yes 2 No lemple Directo 6 corge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.5. 20 2 Kd. apt 12. Was Decedent Ever in U.S. Armed Forces? Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 PNo 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Specify: Black ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industr 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) House 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barksdale 29 INKlex Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place, City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake * 4 ☐ Donation 5 ☐ Other (Specify) 2-21-2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Hous UPShu ST. N. W. Washingfor De. 20011 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ension, hypothismic with Bridge and Ex disease or condition hypotemion /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Division of Vital Records, P.O. Box 68760, Physician/Medical and knowloughopenia IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ESRD Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Dementia certificate has autopsy performed? 2□No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0039255 2-20-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luchibh of la Subbarao, MD 9/31 PISCATAWAY, Sente 750 clinton, nD 2077

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 24

32. Registrar's Signature

			1 - For State Registrar	State of Maryland		tment of F		Reg.	2004	07664
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give s 90') A Y P 5. Social Security Number 6. Sex	treet and number)			r Location of Death	7	Day Year / 4c. County of Death	3. Time of Death Silvery M Grant G
	Funeral Director			M 2□F 59		Months Days	Hours Min.	(Month, Day, Ye	ear) Country) 1944 Washing) .
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show many or other treumatic event, the Medical Evantinal must be notified at 2006.	Funerai Director	Maryland Montgome 10e. Street and Number 907 Laredo Road 11. Marital Status		ilver S	pring 10f. Zip Code 209	901 ispanic Origin? (S			
9600	ours after dural, or Item	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1☆Yes 2□No If Yes, Give Year or Dates:Vietn	If Y	es, specify Cuba	ın, Mexican, Puert	o Rican, etc.)	Black, White, etc. Specify: Whit	
21215-0036	I within 72 h jiene. r than "natu Ine Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give kir	NOT use retired	during most of wor	king 16b	o. Kind of Business/Indust	ry
Maryland 2	should be filed nd Mental Hyg i marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) William Arthur Jone	es	Nevel	worked		ne (First, Middle, Maid Elizabeth	den Sumame)	
altimore, Mar	Pages 1 and 2 shonent of Health and out: If item 27 is mury or other treum		19a. Informant's Name/Relationship (Typ. Deborah McFarland 20a. Method of Disposition 1 ♀ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	Sister	5065 N	W 150th	and Number or Ru	Morristor Date 200	ty or Town, State, Zip Co 1. FI. 32662 . Location - City or Town,	State
Baltir	permit. P Deportme Importen any njur		21. Signature of Funeral Service License	L Cole	Fra	lame and Address ncis J. Univers	ss of Facility Collins	Funeral Ho	shington,D. ome, Inc. er Spring MC	
	Physician /Medical Examiner	Examiner	23a. Pent1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury)	ations that caused the death cause on each line. Due to (or as a consequence to (or a))).	Do not enter to				Ap Int	proximate erval Between set and Death
k 68760,	leath certificate be executed attending physician and for use as the burial-transit	icai	that initiated events resulting in death) Last c.	Due to (or as a consequ						
.O. Box	0 0 0	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ec	topic pregnancy ther (specify)			23d. Date of delivery Month Day	y Year
Records, P	The law requires that the tee has been signed by the bage 2 should be detached.	by	Part II. Other significent conditions cont	ributing to death but not resu	Iting in the unde	rlying cause give	en in Part I.	23e. Did tobacc	2 No 3 Probably	ause of death?
al Reco		Completed						24a. Was an autopsy performed	death?	etion of cause of
ion of Vital	ng Phys Iter this Ineral di	ation: To Be	25. Was case referred to medical examiner? 12 Yes 2 No 27. Manner of Death 1 Statural 5 Pending 2 Accident investigation		ER/Outpatient 28b. Time of Injury	3 DOA Othe 28c. Injury Work M 1 D	er: 4 □ Nursing H	th Check onl one ome Sesidence 28d. Describe how in	6 Other (Specify)	
Division	pitel or Attendi ours after death. erel Director: A filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street	, factory, office		28f. Location (Street City or Town, St	and Number or Rural Ro ate)	ute Number,
	Hos 24 h Fun	Medical	29a. Certifier 1 Certifying Physical Control Check only 2 Medical Examination	icien: To the best of my know er: On the basis of examinati and manner stated.	vledge, death or ion and/or inves	curred at the tim tigation, in my or	e, date and place, pinion, death occur	and due to the cause red at the time, date a	o(s) and manner as stated and place, and due to the	l. cause(s)
Ú	within 2	Z	29b. Signature and title of certifier	eckers.	DME	29c. License	o 428	29d. 1	Date signed (Month, Day,	Year)
			30. Name and address of person who con 200 Name and address of person who con 31. Date filed (Month, Day, Year)	WER, MOD	ME	11) 2101 51/Ve	r Spri	ng mo	2090)	
	Sta Registr		FEB 2 4 200	32. Registrar's Signatu	G	Sparks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004

			1 - For State Registrar	State o	f Marylar		artmen <i>rtificat</i>			and M		giene Reg. No.		07665
			1. Decedent's Name (First, Middle, Last	t)							2. Date of Dea	ath Day	/ Year	3. Time of Death
	Physici /Medic		LIREKA	PAU	JLINE	J(SEPH				FEB	17	2004	10:40 PM
	Examin		4a. Fecility Name (If not institution, give			TOTAL	4b. City,		Location o			4c.	County of Death	
			NATIONAL NAV				If Under		ETHES				MONTG	
	Funeral		5. Social Security Number 6. Se 16	× 2 XF	7. Age (In yrs. 6 I	Yrs.	Months	Days	Hours	Min.	(Month, Day	y, Year)	9. Birth Cou 1942 Mi	place (State or Foreign intry)
	Director		Usuel Residence of Decedent								october	119	1942 MI	Cirigan
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Mar Ba-f st	tor	MD Montgom	ery		Kensin	ngton							1 ☐ Yes 2 No
	ith the	Director	10e. Street and Number				10f. Zip					10g. Citi	izen of What Cou	intry?
	within 72 hours after death with the Maryland liene. rthen "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at		4516 Puller Driv					895					U.S.A.	
	er dei	Funerai	11. Marital Status	Armod Ea	edent Ever in U	J.S. 13.	Was Deceder f Yes, spec	dent of His cify Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	•	 Race - Amer Black, White 	
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9500-6121	2 hou	ed	15. Decedent's Ed	ucation	19/9	16a Dece	dent's Usua	al Occupa	ation			16b. Ki	ind of Business/Ir	ndustry
213	C 60	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de <i>completed)</i> College (d	-4or 5+)				luring most	of worki				
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2	be filed ital Hygi od other svent, t	Be (17. Father's Name (First, Middle, Last)						18. Mother	r's Name	(First, Middle,	Maiden	Sumame)	
yiand	should to the market market umatic a	2	Louis Josep								tha Blu			
Mar	2 sh and ls m	11 7	19a. Informant's Name/Relationship (7) Martha Joseph/ M			19b. Mailir 29723	-				d, Mich		r Town, State, Zi	p Code)
	es 1 and 2 should be fi of Health and Mental F I Item 27 is marked of rr other traumatic sver	1 8	20a. Method of Disposition		20b. 1	Place of Dispo			West		ate PILCII		1 48185 ecation - City or T	own State
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Battimore,			* 4 ☐ Donation 5 ☐ Other-(Specify) 21. Signature of Funcial Solvice License) 22	. Name ar	d Addres	s of Facility	ูป่อรเ				Inc. DC 20016
n	permit. Departr Imports any inj	l, l	And	no	Som	/ 5	130 T	Visco	onsin	Ave	nue NW	Wash	ington l	DC 20016
93.5			23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	olications that c	aused the deal	th. Do not ent	er the mod	e of dying	g, such as o	cardiac c	or respiratory ar	rest,		Approximate Interval Between
	Physician	8 6	Immediate Cause (Final disease or condition	-	METASTA	TTC BR	EAST	CANC	FR					Onset and Death
	/Medical		resulting in death)		or as a consec		LIIOI	OLILIO	LJIV					
	Examiner		Sequentially list conditions,	b										
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consec	quence of):								
9	xecuí	Examiner	that initiated events resulting in death) Last	c. Due to	or as a consec	quence of):								
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9	of phy g phy as the	edi		<u>.</u>										
ROX	eath certific attending p	N/u	Zab. Was decedent pregnant	23c. If yes, out	come of pregn		Ectopic pr	ecnancy				2	23d. Date of deliv	rery
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3,	ries th	þ	Part II. Other significant conditions co	ontributing to de	eath but not res	suiting in the u	naeriying c	ause give	n in Parti.			es 25		the cause of death? bably 4 Unknown
ecord	w require been sign should t	Completed												
ž	e lav has je 2	mpi									24a. Was autop	sy	24b. Were auto prior to co death?	opsy findings available empletion of cause of
	ician: The la certificate has rector, page 2										1 ☐ Yes	2 X No		2 No
Vital	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:		leno:		Othe			(Check only o	1		
Ö	Phys r this ral d		1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of		8c. Injury Work	4 🗆 1901		me 5 L Resid		6 Other (Speci	<i>fy)</i>
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DIVISION	Attendi er death. ector: A by the fu	iffice	3 Suicide 6 Could not be 4 Homicide determined	286. Place	of Injury - At h		eet, factory	, office			28f. Location (S City or Ton			al Route Number,
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	To the Hos within 24 hd To the Fun c- mpletely	Medi	29b. Signature and title of certifier	and man	ner stated.			. License					e signed (Month,	
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	8		20 Name and address of	Ulli	you	m 235) (7)			35480			00	1 1	2007
			30. Name and address of person who o	1		23a) (Type,	i intij				MD 2088		CAL CENT	EK
\$	Sta	ate	31. Date filed (Month, Day, Year)	LT M 32. P	egistrar's Sign	ature	1			JUA	LW 2000		,,,,	
	Registr	rar	FFR 9 5 20	HIA A	2 marson de	109	10	as W.	/					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 12, 2004 Year **Physician** 8:20 P. Lucy Jackson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Crofton Convalescent & Rehabilitation Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Bay, Yang) ADITIL 28, 1920 9. Birthplace (State or Foreign Georgia Social Security Number **Funeral** Days Hours Min. 83 **Director** 050-22-5029 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits wor. other traumatic event, the Madical Examiner must be notified at Crownsville Yes 2 No Anne Arundel Maryland Funeral Directo 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ U.S.A. 21032 or Items 23a 1200 Sun Rise Beach Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Marned Specify: Black Maryland 21215-0036 1□Yes 2XNo Completed by 3 Nidowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Self-Employed (Retired) 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ie marked of Roger Lovett Belinda Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 ie any injury or other trau Mr. Charles Jackson (Son) 1200 Sun Rise Beach Road Crownsville, Maryland 21032 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremetory, Inc. 2/18/04 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROLLINS FUNERAL HOME, INC. 4339 HINT PL. N.E. WASHINGTON, D.C. 4.539 HUNI PL. N.E. WASHINGION, D.C. V. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. 23a. Part. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death **Physician** Cre trounau /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 si autopsy performed? 1 ☐ Yes 2 ◯XNo 1 Yes 2 🕱 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural s after decral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date fled 2. Registrar's Signature (Month, Day, Year) State FEB 2 0 2004 Registrar

			For State Registrar	State of Marylan	Cei	rtificate	of Death		Reg. No		. 0,00
F	Physicia	an	1. Decedent's Name (First, Middle, Las	,				2. Date of D Month 2	Da		3. Time of Death 1:30 a M
	/Medic		Aliza 4a. Fecility Name (If not institution, give	Jan estreet and number)		4b. City, T	own, or Location of De		1 40	7 2004 County of Dear	
Fı	uneral rector		8504 Tahona Dr. 5. Social Security Number 6. S 577-90-0505		last birthday) Yrs.	Silv If Under 1 Months	Year II Under 24 F	g Irs. 8. Date of B (Month, D	irth Day, Year)	9. Birt	Georges hplace (Stete or Foreign nuntry) Kistan
pur	*		Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Maryla	f sho	Į.			lver		g				1 ☑ Yes 2 ☐ No
th with the	23a or 28a lat be nutif	Funeral Director	10e. Street and Number 8504 Tahona Dr	•		10f. Zip 0		3	10g. Ci	tizen of What Co	puntry?
III.Q K I K I STOUSO be filed within 72 hours after death with the Maryland tat Hygiene.	If item 27 is marked other then "natural", or items 23a or 28a-1 show or other traumatic event, Itie Medical Expendent must be nutified at	by	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		Was Decede if Yes, specif	nt of Hispanic Origin? y Cuban, Mexican, Pu X No <i>Specity:</i>	(Specify Yes or Nerto Rican, etc.)	10-	14. Rece - Ame Black, Whit Specify: A S	e, etc.
within 72 ho	then "natur is Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done during most of v retired)	vorking		ind of Business ome	Industry
filed y	other i		17. Father's Name (First, Middle, Last)		11003			lame (First, Middl			
2 should be filed within and Mental Hygiene.	rked c	To Be	Mohammad Han	if			Noor	Jahan	Han	if	
and Men	is ma		19a. Informant's Name/Relationship (Street and Number or				
and 2	m 27 her tr			band			ona Dr.,S				
Definit. Pages 1	Important: If item 27 is eny injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State G 2 0		natory or oth I a s h i 1	ngton 2/1	Date L8/04	Ade	ocation - City or	Md.
permit. Departr	eny in		21. Signature of Funeral Sent of Scen	st 064	1 4	11 K	Address of Facility (ennedy St	.,N.W.	wash	ortuar .D.C.	y 20011
Phys	sician	2 4	23a. P. rt1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death one cause on each line. Metastat				liac or respiratory	arrest,		Approximate Interval Between Onset and Death 3 y r S
	edical miner		resulting in death)	Due to (or as a conseq	uence of):						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	ng physician and as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	c. Due to (or as a consequence of the consequence o						-	
rtificat	ng ph)	Medical	IF FEMALE:								
the death ce	been signed by the attendin should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	I death 3	Ectopic prec Other (spec				23d. Date of del Month	ivery Day Year
requires that	n signed b	by	Part II. Other significant conditions c	ontributing to death but not res	ulting in the u	nderlying cau	ise given in Part I.				the cause of death?
The law re	Director: After this certificate has bee d in by the funeral director, page 2 sho	Completed						per	s an opsy formed? 2 ½ No	prior to death?	topsy findings available completion of cause of 2 No
V I C	ector.	Be	25. Was case referred to medical examiner?	Hospital:			_	eath (Check only	one)		
P P	r this ral dir	. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	I Inpatrent 2	ER/Outpatien 28b. Time of			Home 5 ☑ Res 28d. Describe			cify)
anding sath.	or: After	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	М	c. Injury at Work? 1 ☐ Yes 2 ☐ No	250. 2000.150	mon ma	,, 00001100	
ital or Att	ral Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory,	office	28f. Location City or To	(Street and own, State	nd Number or Ru b)	rai Route Number,
he Hospital n 24 hours a	To the Funeral Discompletely filled in	edical	29a. Certifier 1 ★ Certifying Ph (Check only one) 2 Medical Examone)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or inv	n occurred at vestigation, in	the time, date and plan my opinion, death of	ce, and due to the curred at the time	cause(s) , date and	and manner as d place, and due	stated. to the cause(s)
To the within 2	To ti	M	29b. Signature and title of certifier	1111		29c. l	License number		29d. Da	te signed (Month	n, Dey, Year)
1			• //	All	>		D0033293		Feb	.17,20	04
1 //	1 1		30. Name and address of person who	completed cause of death (Item	23a) (Type	D :					
- (レ		Frederick P.				consin Av	ve,Chev	y Ch	ase,Md	. 20815

Prysician / Modifical Examiner 48. February 11 2004 8:45 Frent and Number 46. City, Town, or Location of Death Ft. Washington 46. City, Town, or Location of Death Ft. Washington 46. City, Town, or Location of Death Ft. Washington 46. City, Town, or Location of Death Ft. Washington 46. City, Town, or Location of Death Ft. Washington 46. City, Town, or Location of Death Ft. Washington 46. City, Town, or Location of Death Ft. Washington 46. City, Town, or Location of Death Ft. Washington 46. City, Town, or Location 46. Ci			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artmen rtificat	t of Hea e of De	alth and Neath			4 0766
Second Second Number 2	/Medic	al	William Jud	dkins street and number)		4b. City,			Februa:	Day Yeary 11 200	04 8:45 A
The Sale 100. County 100.	Director		5. Social Security Number 6. Sex 15 15 15 15 15 15 15 15 15 15 15 15 15	7. Age (In yrs	V		1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day	, Year) 9. I	Birthplace (State or Fore Country)
Transparent properties of the	the Maryland 28a-f show polified at	ector	Maryland Prince		ity, Town or Lo	Ft		nington		10g Citizen of What	10d. Inside City Limi
Trailburs Name (Frest, Middle, Last) Dallas Judkins Dallas J	urs after death with al', or Items 23a or Examiner must be	by Funeral Dir	12000 Hazem Ct. 11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 □XYes 2 □ No If Yes, Give		Was Deced	207 dent of Hispa cify Cuban, M	nic Origin? (Sp fexican, Puerto		Unite 14. Race - A Black, W	d States mencan Indian, the fican
23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate clause (Final disease or condition) and part of the part failure. List only one cause on each line. 25a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate clause (Final disease or condition) and part of the par	s filed within 72 ho I Hygiane. other than "natur. rent, the Wedical i	e Completed	(Specify only highest grade Elementary/Secondary (0-12) 12th	completed)	(Give	kind of wo DO NOT us	rk done durin se retired) ick Ma	ng most of work		Private/S	
23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition) and of the cause of the ca	2 should be and Mental is marked or raumatic ev	ToB	19a. Informant's Name/Relationship (Ty	pe, Print)					ral Route Numbe	r, City or Town, State	
23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition). Examining I and the conditions of the	ermit. Pages 1 and Separtment of Health mportant: If item 27 ny injury or other t ince.		20a. Method of Disposition 1 월 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	20b.	Place of Dispo cemetery, cred	sition (Name and	ne of the Celege) Church d Address of	n 2/1	Date 8/2004 ewart Fu	20c Location - City Clayto neral Hom	or Town, State n NC
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the cause of the cause of the cause of the cause of death of the cause of	Medical Assician and he burial-transit	cal	23a. Part 1 Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	cations that caused the dealer cause on each line. Due to (or as a consection). Due to (or as a consection).	quence of):						
The part of the signature and title of certifier 1 to 1 t	the death certifi y the attending iched for use as	yslcian/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3						
24a. Was an utopsy performed? 25. Was case referred to medical examiner? 1 Yes	50 20	þ	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying c	ause given in	n Part I.		2.20	
The state of the s	The law ate has b page 2 s		25. Was case referred to medical				26	Place of Deat	autops perfor 1 Yes	rged? prior t death 2 No 1 □ Y	o completion of cause o
29a. Certifier (Check only only) 29a. Certifier (Check only only) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ding Phys h. After this funeral dis	မ	1 Yes 2 No Part Natural 5 Pending	28a. Date of Injury	28b. Time o	f 2	Other: 2 8c. Injury at Work?	4 □ Nursing Ho	ome 5 Resid	ence 6 □Other (S	pecify)
	pital or Atte		4 Homicide determined	building, etc. (Spec	ify)				City or Tow	n, State)	
	To the Hosp within 24 ho Fo the Fund completely f	Medica	(Check only 2 Medical Examinations)	ner: On the basis of examin	iowledge, deat ation and/or in	vestigation	, in my opinio	on, death occur	red at the time, d	ate and place, and o	lue to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yau Bone. 10905 Fort Washington R # 2005 Fort Washington My 20744	(2)		30. Name and address of person who co	empleted cause of death (Ite	om 23a) (Type,	Print)	DY	6285		2/1	5 5004

			State of Maryland / Department of Health and M State Registrar State of Maryland / Department of Health and M Certificate of Death	lental Hy	giene 20	04	07669
	M - 9		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of De	ath		3. Time of Death
	Physici	an	Maggie Jacobs	Month Feb. 1	0, 2004	Year	7:30 a ^M
	/Medic		4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	TCD. I	4c. County	of Death	7.30 a
	Examin	er	Southern Maryland Hospital Clinton,		Princ	e Ge	orges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt (Month, Da			lace (State or Foreign etry)
<u> </u>	Director		577-54-3006 1 M 2 F 65 Yrs. Months Days Hours Min.	Aug. 2	1, 1938	D.	
	Q		Usual Residence of Decedent				
	rylan		10a. State 10b. County 10c. City, Town or Location Md. Prince Georges District Heights			1	0d. Inside City Limits TX□ Yes 2 □ No
	h the Marylan r 28a-f show	cto					
	₩ 0 ₩	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of V	hat Coun	itry?
	ath w		6019 Belwood Street 20747		U.S.		
	ler dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)		e - Americ k, White,	
9	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X ☐ No 1 ☐ Yes Give 1 ☐ Yes 2X ☐ No Specify: 3 ☐ Widowed 4 ☐ XDivorced Year or Dates:		Specify	: Bla	ck
Š	be filed within 72 hours after tall Hygiene. d other than 'natural', or lie event, the Macinal Examine.		3 Widowed 4 XDrvorced Year or Dates: 15, Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bu	siness/Inc	dustry
7 4	n 72	iete	(Specify only highest grade completed) (Give kind of work done during most of work life, DO NOT use retired)	ing	TOD. TIME OF DE	on load in	accity
ATP.	with the r	Completed	Elementary/Secondary (0·12) College (1·4or 5+) 12th Asst. Chef		Marri	ott	Corp
3	Hyg Hyg ent,	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,	Maiden Sumam	θ)	
5	id be ental ked of	To B	William Seabrook Helen H	lawkins			
Ì	shound M	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	a <i>l R</i> oute Numbe	er, City or Town,	State, Zip	Code)
7	ING 2 Allha 27 is r tra		Catherine Daniels (Daughter) 1362 Geranium St., N.	W. Wash	ington,	DC 2	20012
2	s 1 a f Heg item othe		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location -		
ha/o,	Page ento		1 Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 02-17	7-04	Washing	ton,	DC
2/10/04 70 Am	peatitions, including praise and also records to the records of th		21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.	H. Baco	n Funer	al Ho	ome, Inc.
ï	407 40		23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac		nington,	р. (Approximate
	Dhamisian		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Julianumy Em	Roll	86-		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	11000	3 7-7		In Known
	Examiner		Hard-Hard-September (All March 1995)				
	χ'	er	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
	exec exec in an		resulting in death) Last Due to (or as a consequence of):				
75.	of ou, cate be executed bysician and the burial-transit	dicai	d				
(oo tificat ig phy as th	Φ.					
	ndir use	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant 1		I	e of delive	,
	death death e atte	icia	in the past 12 months? 1 Yes 2 No		Mo	nth	Day Year
5	that the ded by the detached	hys	9 Unknown				
acco	HECOLOS, P.O. he law requires that the d e has been signed by the tge 2 should be detached	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				ne cause of death?
2	w require	ed l	Chrone Renal disease	1 🗆 '	Yes 2 ☐ No	3 Prob	ably 4 Dunknown
B	aw requ	plet		24a. Was	an 24b.	Vere auto	psy findings available apletion of cause of
. / 6	The I	E		perfo	rmed?	leath?	
. 7	VICAN REC iician: The lav certificate has rector, page 2	0	25. Was case referred to medical 26. Place of Deat				
8	OI VITA Physician: this certific ral director,	0 8	examiner 1 Dos 2 No Hospital: 1 Doatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Ho	ome 5 Resi	dence 6 □Oth	er (Specify	y)
2	g Ph ig Ph ter th	T:u	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe	how injury occurr	ed	
3	Attending r death. ector: After	atic	2 Accident investigation M 1 Yes 2 No				
₹ :	LIVISION I or Attending after death. Director: After	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (: City or Tox	Street and Numb wn, State)	er or Rura	l Route Number,
Č	tal or rs afte at Direct Inc.	Cer					
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, consider the time of the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the red at the time,	cause(s) and ma date and place,	nner as st and due to	tated. the cause(s)
	o the vithin 2 o the omple	Me	29b. Signature and little of certifier 29c. License number		29d. Date signer	d (Month,	Day, Year)
	PSPO		1 50454		Eebus	ans	212204
0	(F)	-	30, Name and address of person who completed cause of death (Item 23a) (Type, Print)	/	- ,		,, <u>-,</u> -,-,
CF	(3)		HRASTOO Gazdani 9400 Livingston Rd Ft	Wast	ringto.	Ω, N	,12,04
	St Regist	ate rar	FEB 1 8 2004				

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1

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	1	For State Registrar		Cei	rtificate o	f Death		Reg. No.	0101
Physicia	n	1. Decedent's Name (First, Middle, Last) E11a	Louise Bet	hel Ja	rvis		2. Date of De Month Febru a	ath Day Year 2004	3. Time of Death 4:30P.
/Medica Examine	- 4	ta. Fecility Neme (If not institution, give s		iter		o, or Location of Dea		4c. County of Deet Prince G	
Funeral Director		5. Social Security Number 6. Sex 579-36-1910	7. Age (In y	rs. last birthday)	If Under 1 Yes Months Day		8. Date of Birt (Month, De December	y, Year) 1929 9. Bird er 4, Sou	hplace (State or Fore untry) th Carolin
Maryland		Usual Residence of Decedent 10a. State 10b. County Maryland Prince		City, Town or Lo	Rainie	r			10d. Inside City Lim 1 XYes 2 ☐ I
3e or 28	ai Dire	10e. Street and Number 3817 - 33rd Stre	et		10f. Zip Code	∍ 712		10g. Citizen of What Co United St	
o',le	by Fur	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □Yes 2X No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C	of Hispanic Origin? (uban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No irto Rican, etc.)	1	
within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 2 years	(Give	dent's Usual Occ kind of work do DO NOT use ret se Aide	ne during most of w	orking	16b. Kind of Business	
12 should be filed within h and Mental Hygiene. 7 ie marked other than " freumatic event, the Max	Be Co	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
d Mente	2	Robert Whitner 19a, Informant's Name/Relationship (Ty		19h Maili	no Address /Stm			thel Zeiglen or, City or Town, State, 2	
and 2 st ealth and n 27 te r	1	Newton Henry Jarv		1				nier,Maryla	
Pages 1 and inent of Health out: If item 27 ary or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	cemetery, crea	matory or other p	relatoyr, Il	Date . 10,2004 Nc.	20c. Location - City or Beltsville,	
permit. Pages Department of Importent: If it eny injury or on		21. Signatu Funeral Service Licens	Cam	22	R. N. Ho	dress of Facility Orton Com nedy Stre	pany Mort	ticians, In Washington,	c. D.C. 2001
Physician /Medical		23a. Pert1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the dine cause on each line. PRCBAB Due to (or as a cons	LE B					Approximate Interval Between Onset and Deatl
rilicate be executed g physician and as the buriat-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons		-				
ath certif ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregna □ Other (specify)			23d. Date of de Month	livery Day Year
gne be c	۵	Part II. Other significant conditions co	A IN K	REMIS.	51014	given in Part I.		obacco use contribute to Yes 2: 万- No 3 □ Pi	the cause of death
e law r has be je 2 sh	Completed	History o	OF HYPE	RTENS	10N			rmed? death?	utopsy findings avai completion of cause 2 2 No
certific	Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital:	P FR/Outcatie	nt 3 DOA	Othor	eath (Check only o	one) dence 6 □Other (Spe	city)
0 in a	ition: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o	of 28c. I	njury at Work?		how injury occurred	ony
al or Atter s after dea I Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, st ecify)	reet, factory, offi	се	28f. Location (City or To	Street end Number or R wn, State)	ural Route Number,
2 2 0 0	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	vsician: To the best of my iner: On the basis of exam and manner stated.	knowledge, dear nination and/or in	th occurred at the	e time, date and pla ny opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
e Hosp 124 hou e Fune letely fil	O				29c Lic	ense number		29d. Date signed (Mont	h Day Voor
To the Hosp within 24 hou To the Fune completely file	Med	29b. Signature and title of certifier	j	_					
To the Hospital or Attending within 24 hours after death. To the Funerell Director: A completely filled in by the fu	Med	29b. Signature and title of certifier Sc. Signature and address of person who compared to the signature and address of the signature and addr	ompleted cause of death (D	00/55	58	02-07	

State of Maryland / Department of Health and Mental Hygiene For State Registrar 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** E119 chason 26 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death Examiner Prince hever rince pital 11 George tf Under 1 Year | If Under 24 Hrs. Birthplece (State of Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🖼 🕈 578-34-7537 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Itema 23a or 28a-1 show Examiner must be notified at 1 Yes 2 No Suitland Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20746 Hvenue Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Black Specify: by 3 1 Widowed 4 □ Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 hc Depertment of Health end Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Madical I once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Estelle Inknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Johnson Son David L. 20 Washing 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Description 2 Cremation 3 ☐Removal from State Vashington National Feb 21,2004 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Welliams Washington De alph 6 20003 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner PNEUMONIF Sequentially list conditions, if any, leading to immediate the first line of the fir Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed MELLITUG 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an URI NARX 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 2 1 ☐ Yes 2 ☐ MG N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 27. Manyrer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be etermined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0043662 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 300/ Hospita 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2004 Registrar

		1 - For State Registrar	State of Maryla	nd / Depa <i>Cel</i>	artment of F	lealth and <i>Death</i>		giene 2 (104	07672
Physici /Medio		•	nes 				2. Date of De.	18 ^{ay} 20) 6 24	3. Time of Death 7:30 pm
Examin	er	4a. Facility Name (If not institution, give s 820 Somerset 1			4b. City, Town, o Hyatt	r Location of Dec sville		P.G.		
Funeral Director			7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mil	8. Date of Bird n. (Month, Da May 4	1943	Cour	place (State or Foreign try) Ville, Va.
death with the Maryland ms 23s or 28s-1 show finast be notified at	tor	Usuel Residence of Decedent 10a. State Md. 10b. County P.G.	10c. C	ity, Town or Lo	ville				1	0d. Inside City Limits 1 Yes 2 □ No
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5 2 3	by Funeral	11. Marital Status 1 □ Never Mamed 2 □ Married 3 □ Widowed 4 ☒ Divorced	2. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☐ Note of the Yes, Give Year or Dates:		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 █️No	lispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or No ento Rican, etc.)	Blad	e - Americ k, White,	etc.
Z I Z I 3-0036 3 within 72 hours af piene. r then "naturel", or the Modical Example.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired Self-em	during most of w		16b. Kind of Bu		•
be file tal Hygel of othe event,	To Be Co	17. Father's Name (First, Middle, Last) James Floyd					ame (First, Middle, Sie Bank		e)	
2 sho and I		19a. Informant's Name/Relationship (Type Perry Jones - Sc		19b. Mailir 993	Address (Street Hether	and Number or P	Rural Route Number	r, City or Town, ederic	State, Zip Md.	Code) , 21702
Saltimore, IN Permit. Pages 1 and 1 Deperment of Health mportent: If Item 27 nny injury or other tr		20a. Method of Disposition 1	amount from State	cemetery, crer	sition (Name of natory or other place n Memor:	Fel	Date 25,04	20c. Location - Suitla	City or To nd N	wn, State 1d •
Daltimo permit. Pages Depertment of Importent: If It any injury or once.		21. Signature of Funeral Service License	dobuse	22	Name and Address Robinson	ss of Facility	cal Home Wash.	1313 D.C. 2	85b1	St.N.W.
Physician /Medical		23a. Part — I ter the disease, or complication, or heart failure. List only on immediate draws (Final disease or condition resulting in death)	cations that caused the deale cause on each line. Renal Due to (or as a conse	ith. o not ent	er the mode of dyin					Approximate Interval Between Onset and Death
occificate be executed certificate be executed certificate be executed certificate and certificate as the burial-transit certificate as the burial-transit certificate.	cal Examiner	Sequentially list conditions, Tary, leading to immediate cause. Enter Underfund Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quanca 31):	hellit	45				
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wrequires that been signed be should be detailed	by P	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause give	en in Part I.			bute to th	e cause of death?
The law The law ate has b	Completed						24a. Was autop perfor	med? d	Vere autor prior to con leath?	osy findings available npletion of cause of 2 \(\text{No} \)
Of VICEL P Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Xes 2 No	ospital:] ER/Outpatien	t 3 DOA Oth		eath (Check only on Home Resid		er (Specifi	·1
Jing Jing After fune	atlon: T	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	v at	28d. Describe h			/
2 등 원 등 교	Certificati	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injury - At to building, etc. (Special Control of the Control of th	nome, farm, str ify)	eet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	er or Rura	Route Number,
e Hospital 24 hours a Funeral i	edical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, o	ause(s) and mai late and place, a	nner as stand due to	ated. the cause(s)
To the Hos within 24 hr To the Fun completely	Me	29b. Signature and title of certifier	flooting.	PU	29c. Licenso		>	Pehren	(Month, L	Day, Year)
(iv)		30. Name and address of person who con	mpleted cause of death (Ite	m 23a) (Type,	Print)	Ches	ed h	1972 /4m	12	1201
Sta Registr		31. Date filed (Month, Day, Year) FEB 2 3 2004	32. Registrar's Sign	ature	,		11			

State of Maryland / Department of Health and Mental Hygiene 2004 07673 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Clyde Judd 12:00A M 02 20 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Leonardtown
Under 1 Year | If Under 24 Hrs. | St Mary' St. Mary's Nursing Home 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ F 94 Director 1909 Sanford, NC 579-54-3877 12 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itama 23a or 28a-f show the Medical Examinar must be notified at DC 1√2 Yes 2 No Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1345 A Street N.E. 20002 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2 yrs. Mail Handler s 1 and 2 should be filed w if Health and Mental Hygier itam 27 is marked other th other traumatic event, thi U. S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William H. Judd Maggie Judd 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If itam 27 i 36955 Ricky Drive Bushwood, Md. 20618 Clarice Knotts Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If sny injury or once. Maryland National 2-26-2004 LAurel, MD. ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee maishall 4217 9th. St. N.W. Washington, D.C. 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between On, et and 3, at Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequer Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence P.O. Box 68760. attending physician Physiclan/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) the detached 9□ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 124a. Was an certificate has page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No To 1 Inpatient 2 ER/Outpatient 3 DOA SIL funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after hin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 2 5 cause of death (Item 23a) (Type, Print)
1585 Peabody Street Leonardtown, Md. 30. Name and address of person who complete Jarboe, MD James P/. 2 4 2004 32. Registrar's Signature State morte Registrar

			1 - For State Registrar	State of M	Maryland / D	epartmer Certifica	nt of H	lealth a Death	and Me		giene	11111.	07674
ı	Physici	20	1. Decedent's Name (First, Middle, Last		- 1					2. Date of De		Year	3. Time of Death
	/Media	al	KENNETH,	JULIA						FEB	21	2004	
1	Examir	er	4a. Facility Name (If not institution, give UNIVERSITY OF MAI			- 1		Location				ounty of Death	
	Funeral		5. Social Security Number 6. Se	x 7.	Age (In yrs. last birtl	nday) If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Bir	th	9 Rinth	place (State or Foreign
L	Director		310 40 2007	XM 2□F	64 Y	rs. Months	Days	Hours	Min.	Nov. 2	3,193	9 Peni	nsylvania
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Mary -1 aho	tor	MD Howard		Lau	rel							1 ☐ Yes 2 🛣 No
	or 28a	Director	10e. Street and Number				Code C				10g. Citize	n of What Cou	ntry?
	23a c	rai D	6 Cross Street					20723				USA	
	er de litems	Funerai	11. Marital Status	12. Was Decede Armed Force	s?	13. Was Dece If Yes, spe	dent of H cify Cuba	ispanic Ori In, Mexican	gin? (Spec n, Puerto R	city Yes or No Rican, etc.)) - 14.	Race - Ameri Black, White,	
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f ahow ont, Ite Medical Examin or marke mylified at	by F	1 ☐ Nøver Married 2 📆 Married 3 ☐ Widowed 4 ☐ Divorced	1 TYPes 2 [If Yes, Give Year or Date:	∍No s: 1959–61	1 ☐ Yes	2 No	Specify:			Sp	pecify: Wh	ite
Ö	2 hou	ted	15. Decedent's Edu	cation	16a. I	Decedent's Usu	al Occup	ation	A = 4 = -4 i=	_	16b. Kind	of Business/Ir	ndustry
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Ž	1 and 2 Health a tem 27 is		Fedret J. Julian	/ spouse		000 01d						21114	ŕ
ore	of He of He It item		20a. Method of Disposition 1 X Burial 2 Cremation 3 F	Removal from Sta	20b. Place of cemetery	Disposition (Na r, crematory or	me of other plac	(8)	Da			ion - City or T	own, State
Ě	Pages tment of I tant: If it		* 4 □ Donation 5 □ Other (Specify)		MD. Ve	terans	Ceme	tery	3-2-	-2004	Che1t	enham,	MD.
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinating market redified at ORGS.		21. Signature of Funeral Service Licent	9	01					all Fur			71.5
			23a. Part1. Enter the disease, or comp	lications that caus	ed the death. Do no					ay Bow		D. 20	715 Approximate
ä	Physician		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each	line.		,	3,					Interval Between Onset and Death
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	Examiner		Sequentially list conditions	MYOC	ARDIAL	INFAI	RCTI	ON					
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	and and II-trans	Examiner	that initiated events resulting in death) Last	cDue to (or a	as a consequence of	n:							
8760,	cate be executed physician and the burial-transit	dical E		4		,							
9	tificate g phy as the	ledic		u									
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<u>Ч</u>	d by the	Phy	9 ☐ Unknown Part II. Other significant conditions con			the condent in a		an in Band I		OZ- Dida			
ords,	w requires the been signed should be d		Part II. Other significant conditions co.	minoding to death	Dut not resulting in	the underlying (ause give	an in Parti.					he cause of death? pably 4 _Unknown
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ā	s afte	Certification;	4 Homicide determined	building,	etc. (Specify)					City or Tow	m, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the besis ner: On the basis and manner	st of my knowledge, of examination and stated.	death occurred for investigation	at the tim , in my or	ie, date and pinion, deat	d place, an	d due to the d	cause(s) and date and pla	d manner as s ice, and due to	tated. the cause(s)
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_	U lkg		30. Name and address of person who co	mpleted cause o	ne St.	ype, Print) Balti	Purv	ee Ga	ndhi,	M.D.			
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			1 - For State Registrar	State of Maryland		artment of H			giene Reg. No. 2	004	07675
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	Director		Usuel Residence of Decedent	7. Age (In yrs. I	Yrs.	Months Days	Hours Min	8. Date of Bird Month, Da 10-3-5	3 Year)	FRONT	ROYAL, VA
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5-0036	a within 72 hours after deeth with the Maryla Jene. r than "natural", or items 23a or 28a-1 shov The Madical Examiner muni be notified at	by Funeral	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.! Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (: in, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	В	Race - Americ Black, White, cify: BLA	etc.
7-61212	I within 72 h jiene. r than "natu the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)		(Give life. l	dent's Usual Occup kind of work done of DO NOT use retired TION & MA	during most of wo d)	orking		Business/Ind	
/land	be filed ntai Hyg ed othe event,	To Be C	17. Father's Name (First, Middle, Last) LINWOOD T. JOHNS	МС			18. Mother's Na ELIZA	me (First, Middle, CALLIS	Maiden Sum	ame)	
, mar	d 2 h a tra		19a. Informant's Name/Relationship (Tyge ELIZA C. JOHNSON-I	MOTHER	211 F	ARRAGUT		W. WASH.	, DC 2	0011-4	125
ıımore	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other onca.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State LE	emetery, cren E'S CR	sition (Name of natory or other place EMATORY	2-	27-04	CLINT	ON, MD	
Balt	permit. Departn Importe any inju		Theodore C.	Tinckner	5	Name and Address 24 - 8TH	ST., N.	E. WAS	H., DC		
di di	Physician /Medical Examiner		23a. Fart1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	s erstie					'લાં દ	Approximate Interval Between Onset and Death
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ras, P.	requires that the de een signed by the a nould be detached f	by Р	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.		obacco use co res 2 🗆 No		ne cause of death?
II Kecord	The law ate has b page 2 st	Completed						24a. Was autop perfor 1 🗆 Yes	rmed?	b. Were autop prior to con death? 1 Yes	psy findings available npletion of cause of 2 No
Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 I	ER/Outpatien	t 3 DOA Oth	000	ath (Check only o		other (Specifi	()
VISION OF	ding h. After fune	ation: T	27. Manner of Death Natural 5 Pending Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	/ at	28d. Describe h			,
DIVIS	in Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stro /)	eet, factory, office		28f. Location (S City or Ton		nber or Rura.	l Route Number,
	Hos 24 h Fur	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Exeminate	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the ting estigation, in my o	ne, date and plac pinion, death occ	e, and due to the ourred at the time, o	cause(s) and date and place	manner as st e, and due to	ated. the cause(s)
0	To the comple	M	29b. Signature and title of certifier	Chest 3	8	29c. Licens			29d. Date sign	•	
_	(10)		30. Name and address of person who co	moleted cause of death (Item		Print) Dein	~ Che	verle	Men	lasso	13 Zeisk
	Sta Registi		31. Date filed (Month, Day, Year)	Registrar's Signal	ture	P. O		"	/		

1. Decedent's Name (First, Middle	D			
	, Last)	partment of Health and ertificate of Death	R:	19. No. 2004 076
Troy	Johnson		2. Date of Deat Month	_ i 3/ lime of Dan
4a. Facility Name (If not inevision			FERRIADI	t 15 Acc
PRINCE GEORGE'S	HOSPITAL CENTED	4b, City, Town, or Location of Oe	eath	4c. County of Death
o. Social Security Number		CHEVERLY		PRINCE GEORGE's
5.79-06-6602	IMM 2 F	Manufactor 17	rs. 8. Date of Birth	9 Airmstee (State of State of
Usual Residence of Decedent	32		Sept. 1	D
10a. State 10b. County	10c. City. Town or I	Aration		9, 1971 Wash, r
DC				10d. Inside City Lin
.10e. Street and Number	wasni			132 Yes 2 □
1524 28th st		10f. Zip Code	10	3. Citizen of What Country?
11. Marital Status	40.44	20020		
1 XNever Married Z Marrier	Anned Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No-	United States 14 Race - American Indian
3 Widowed 4 Divarged	If Yes, Give	1 Type 2 To No. 5	no Hican, etc.)	Black, White, etc.
15 Decodosta	Education			Specify:
Copulary Only ragnest of	(Give		16	Black b. Kind of Business/Industry
— an indicate (0.12)	College (1-4or 5+)		riang.	— or premiessingustry
17. Father's Name (First, Middle Las	3	Clerk	(,T,	ustice Dept.
		18. Mother's Nar	ne (First, Middle, Mail	den Sumame)
19a, Informant's Name/Baintia		Carle	++- T-3	
Carletta tast	TOO. INTERIOR	g Address (Street and Number of Ru	(a) Route Number C	to as Town
208, Method of Discording	1 4 0	DOX NII Over	Lili I	or I own, State, Zp Code)
1 28urial 2 Commiss a C		ition (Name of	Date Co.	• 20745
C_ALIGNOR 3 Children (2Decil	Resurrec	tiony or other place)	200	Location - City or Town, State
11. Signature of Funeral Service Lice	1500	Name and Address of Cours	3/04 C	linton, Md.
- sance ?	Murisch 130	10 C41. H	ogges & F	
38. Party Enter the disease, or com	plications that caused the death. Do not set at	to Sifver Hill	Rd.,Sui	tland, Md. 20746
equentially list conditions, any, leading to immediate luse. Enter Underlying auto (Disease or injury at initiated events sulking in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of);	a luis		Interval Between Onset and Desth
	d			
FEMALE:	30- 4			
1 Past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time at death 5 Ct	her (specify)		23d. Date of delivery Month Day Year
B. Other significant conditions cor	inbuting to death but not resulting in the under	MID CAUSE OFFICE IS OF 1		
		* A AMONG AND AND IN PART!		DNo 3 Probably 4 Dunknown
			24a, Was an	
Was case referred to martinal				24b. Were autopsy findings evailable prior to completion of cause of deaths.
Xaminer?	ospital:	26. Place of Death /		1 2 Yes 2 No
Manner of Death	I Inpatient 2 DER/Outpatient at	DOA Other 4 Nursing Home	5 Paris	QV475
☐ Matural 5 ☐ Pending	(Month, Day Year) 28b, Time of Injury	28c. Injury al 28	d. Describe how indica	
Suicide 6 □ Could not be		I 1⊡Yes orther C	10	COPLINEDOCUITS
☐ Homicide determined	259. Place of Injury - At home, farm, street, is building, etc. (Specify)			
Certifier 4D c			City of Town, State)	Number of Rural Floute Number.
(Check only 250 Medical Examine				
Signature and title of cartifler	clan: To the best of my knowledge, death occur of: On the basis of axamination and/or investign and manner stated.	ation, in my opinion, death occurred	et the time, date and	and mariner as stated.
	0	29c. License number		
A CONTRACT CANTILLER	S U4		1 294 Onto	
Mounte me	Male un.	OCME	FEBRI	signed (Month, Day, Year)
who and address of person who comp	Place M. Pleted cause of deeth (Horn 23a) (Type, Print)		FEBRU	ARY 15,2004
who and address of person who comp	Pletted cause of death (from 23a) (Type, Print) ORFIL 111 Pregistrar's Signature	OCME Penn Street, Ba	FEBRU	ARY 15,2004
The season of the Community of the Commu	5.79 - 0.6 - 6.6 0.2 Usual Residence of Decedent 10a. State Tob. County DC 10a. Street and Number 1.524 28th St. 11. Marital Status 1 (Shever Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g Elementary/Secondary (0.12) 17. Father's Name (First, Middle, Lass Reginald T 19a. Informant's Name/Relationship Carletta Leftw Oa. Method of Disposition 1 (Sheural 2 Cremation 3 C 4 (Donation 5 Other (Specify) 17. Signature of Funeral Service Licer 18. Signature of Funeral Service Licer 19a. Information 5 Other (Specify) 19a. Signature of Funeral Service Licer 19a. Information 5 Other (Specify) 19a. Signature of Funeral Service Licer 19a. Signature of Funeral Service Licer 19a. Was decedent pregnant was present of the service Licer 19a. Was decedent pregnant of the past 12 months? 19a. Unknown 19a. Unknown 19a. Unknown 19a. Other significant conditions conditions 19a. Unknown 19a. Other significant conditions conditions 19a. Case referred to medicat was present of the past 12 months? 19a. 2 No language of investigation of the past 12 months? 19a. Case referred to medicat was present of the past 12 months? 19a. Case referred to medicat was present of the past 12 months? 19a. Case referred to medicat was present of the past 12 months? 19a. Case referred to medicat was present of the past 12 months? 19a. Case referred to medicat was present of the past 12 months? 19a. Case referred to medicat was present of the past 12 months? 19a. Case referred to medicat was present of the past 12 months? 19a. Case referred to medicat was present of the past 12 months? 19a. Case referred to medicat was present of the past 12 months? 19a. Case referred to medicat was present of the past 12 months? 19a. Case referred to medicat was present of the past 12 months? 19a. Case referred to medicat was present of the past 12 months?	S.79 - 0.6 - 6.602 IZIM 2 F	Second property Second pro	Second Security Number Second Security Number Second Security Number Security Securit

		•	For State Registrar	State of Maryland /	Certificate of	Health and Me <i>Death</i>	ntal Hyglen Reg. N	2004	07677
			Decedent's Name (First, Middle, La.	st)	······································	2	. Date of Death		3. Time of Death
	Physicia		Michael Rich	nard Kines		F F	Month D ebruary 1	2004	1:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, o	or Location of Death		c. County of Death	1 1 1 0 0 11
			11924 Mid Cour	nty Drive	Mo	nrovia	F	rederick	
	Funeral		Social Security Number 6. S		Months Days	If Under 24 Hrs. 8 Hours Min.	. Date of Birth (Month, Oay, Yea	r) 9. Birthp	lace (State or Foreign
	Director		214-42-5102	M 2□F 58	Yrs.	1		945 Mary	
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location			1	0d. Inside City Limits
	Aaryita I sho	ō		1- Manage					1 ☐ Yes 2X No
	28a-	Director	Maryland Frederic	k Monr	10f. Zip Code		10a. C	Citizen of What Cour	itry?
	with be or	<u></u>		Destar	21770		IIm	ited Stat	,
	ns 2:	era	11924 Mid County 11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of I	Hispanic Origin? (Speci	fv Yes or No-	14. Race - Americ	an Indian,
(0	or iter	Funeral	1 Never Married 2⊠ Married	Amed Forces? 1X1Yes 2 □ No 1966	If Yes, specify Cub	an, Mexican, Puerto Ri	can, etc.)	Black, White,	etc.
21215-0036	hours after death with the Maryland turel', or items 23e or 28a-f show al Examinar must be notified at	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1968	1 ☐ Yes 25☑ No	Specify:		Specify: Whi	te
5-0	72 hc	Completed	15. Decedent's Ed (Specify only highest gra		Sa. Decedent's Usual Occup (Give kind of work done	during most of working	16b.	Kind of Business/Inc	iustry
21	ithin Ber	ф	Elementary/Secondary (0-12)	College (1-4or 5+)	life. OO NOT use retire			_	
2	tygier her ti		17. Father's Name (First, Middle, Last,		<u>ssistant Man</u>	ager 18. Mother's Name (feway Sup	ermarket
Maryland	htat H ad of	Be					rii st, Middie, Maide	ŕ	
ž	d Meid d Mei marki metic	ဥ	Albert 19a. Informant's Name/Relationship (Kines	9b. Mailing Address (Street	Alice	Route Number City	Tucker	Code
₹	d 2 sho th and I 7 is me treume				1924 Mid Cou				
ō,	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mentat Hygiene. Item 27 is marked other than "neturel", or items 23e or 28e-f show item 27 is marked other than "neturel", or items 23e or 28e-f show other treumetic event, the Medical Examinar must be notified at	1	Beverly Kines / 20a. Method of Disposition	20b. Place	of Disposition (Name of	Dat		Location - City or To	
<u>o</u>	ages ont of t: if i		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	JHemoval from State	tery, crematory or other pla aven Memorial	1	004 Fro	derick, M	laryland
altimore,	permit. Pages Department of H importent: If ite any injury or ot		21. Signature of Fungral Service Licer			ess of Facility Stauf			
ä	Depa impo any ir once	ë s	NASA	- 444		sumtown Pil			
			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. D	T 1			1014 11017	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Pulmonary Fibr	costs	•			Onset and Death 5 years
	/Medical		resulting in death)	Due to (or as a consequence					J years
	Examiner		Sequentially list conditions,	b					
	D #	ner	cause. Enter Underlying	Due to (or as a sonsequent	(a of):				
	and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence	ea of):				
8760,	icate be executed physician and s the burial-transit	al E			.5 017.				
687	phys s the	edical		_ d					
Box (death certific e attending p ad for use as	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of delive	ry
	death a atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		у		Month	Day Year
Ö.	that the de ed by the detached	hys	9 Unknown	9□ Unknown					
s, D	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions of		in the underlying cause give	ven in Part I.		use contribute to th	
ord	w requir been si should	ted	Diabetes Mellitu	IS			1 Tes	2 XNo 3 ☐ Prob	ably 4 Unknown
Records,	e taw r has be je 2 sh	Completed					24a. Was an autopsy	prior to cor	osy findings available inpletion of cause of
<u> </u>	Th ate pag	S					performed? 1 ☐ Yes 2 🔼 N	death?	2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hannitals	T _{OW}	26. Place of Death /	the second secon		
fo	76	0	1 ☐ Yes 2 🕱 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 DOA 000. Time of 28c. Injur	ner: 4 Nursing Home	5 X Residence d. Describe how inju		"
5	Phys this al di) —	27 Manner of Death				a. Describe now inju	ury occurred	
	Jing After fune) —	27. Manner of Death 1. Natural 5 Pending	(Month, Day Year)	Injury Wo	rk?			
isi	tending leath. tor: After the fune) —	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) 10 28e. Place of Injury - At home,	Injury Wo M 1 □	rk? Yes 2□No	f. Location (Street a	and Number or Rura	l Route Number,
Division	or Attending ter death. irector: After n by the fune) —	1 Natural 5 Pending investigation	(<i>Month, Day Year</i>)	Injury Wo M 1 □	rk? Yes 2□No	f. Location (Street a City or Town, Sta	and Number or Rura te)	l Route Number,
Division	or Attending ter death. irector: After n by the fune	Certification; T	1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)	Injury Wo	rk? Yes 2 □ No	City or Town, Sta	te) s) and manner as st	ated.
Division	or Attending ter death. irector: After n by the fune	Certification; T	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Certifying Ph 2 Medicel Exer	(Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)	Injury Mon 1 Gram, street, factory, office	rk? Yes 2 No 28'	d due to the cause(at the time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
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Division	or Attending ter death. irector: After n by the fune	Certification; T	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who	(Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify) sysician: To the best of my knowled niner: On the basis of examination and manner stated.	Injury Month of the factory, office sign, death occurred at the time and/or investigation, in my of the factory. 29c. Licens D2654 (Type, Print)	rk? Yes 2 \sum No 28' me, date and place, and ppinion, death occurred se number	d due to the cause(at the time, date ar 29d. D	s) and manner as st nd place, and due to ate signed (Month, I	ated. the cause(s) Day, Year)
Divisi	or Attending ter death. irector: After n by the fune	Medical Certification; T	1 Matural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	(Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify) aysician: To the best of my knowled niner: On the basis of examination and manner stated. Completed cause of de th (Item 23a arger 16220 Fred	Injury Month of the farm, street, factory, office lige, death occurred at the tit and/or investigation, in my of the farm of t	rk? Yes 2 \sum No 28' me, date and place, and ppinion, death occurred se number	d due to the cause(at the time, date ar 29d. D	s) and manner as st nd place, and due to ate signed (Month, I	ated. the cause(s) Day, Year)

		·	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of He rtificate of D			jiene 	4 07678	
	Physici		Decedent's Name (First, Middle, Last)	aminski				2. Date of Dea Month Februar	Day Yea	0 - 0 - M	
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death			7 20 3 200	4c. County of Deeth	
	LAUIIII		Kline Hospice House			Mt. Airy			Freder	rick	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ahow Department of the traumatic avent, the Medical Exating in the first must be rediffed at any injury or other traumatic avent, the Medical Exating in the first must be rediffed at 2000.	Director	5. Social Security Number 6. Sex		(In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 5,	9. 1 1911 Mi	Birthplace (State or Foreign Country) LChigan	
Baltimore, Maryland 21215-0036			Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits	
			1VWas 2 DNa								
			Maryland Frederi	10f. Zip Code			10g. Citizen of What Country?				
			2607 Warren Way			21701			United States		
		era		12. Was Decedent E	ver in U.S. 13.	Was Decedent of His	spanic Origin? (Sp	pecify Yes or No-	14. Race - A	merican Indian,	
		by Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2XXVI If Yes, Give Year or Dates:		lf Yes, specify Cubar 1 □ Yes 2 XX No	Specify:	o Rican, etc.)	Black, W Specify: V		
		ted	15. Decedent's Education 16a. [(Specify only highest grade completed)		16a. Deced	cedent's Usual Occupation ve kind of work done during most of working			16b. Kind of Business/Industry		
		To Be Completed by Funeral	Elementary/Secondary (0-12) College (1-4or 5+)			DO NOT use retired)					
			0		Cus	todian			Education	1	
			17. Father's Name (First, Middle, Last)						Maiden Sumame)		
			Walter Blusiewicz Rozalia (19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rou						(Unknown)		
			John Kaminski/ So						land 2170		
			20a. Method of Disposition	11	20b. Place of Dispo			0.981	20c. Location - City		
			1 X Burial 2 □ Cremation 3 □ F 1 4 □ Donation 5 □ Other (Specify)		1		l	17 20V	4 Frederic	de Marrull and	
alti	mit. F partm portar / injui		21. Signature of Funeral Service Mcens						uneral Ho		
ä	Depariment once	1 2	MAND G	o e sea						yland 21702	
of Vital Records, P.O. Box 68760,	Physician /Medical	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition PANCREATIC CARCINGHA MO							Interval Between Onset and Death	
			disease or condition resulting in death)	Due to (or as a consequence of):						140	
	Examiner		Sequentially list conditions								
	D =		if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of).							
	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	каш	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):							
		Completed by Physician/Medical									
			d.								
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	100 mg		23d. Date of Month	delivery Day Year	
	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause							to the cause of death?	
	v requires tha been signed I should be det							1 🗆 Ye	es 2 No 3	Probably 4 Unknown	
						24a. Was a autops perfori	med? prior death				
			25. Was case referred to medical	1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)							
	OF CO	To Be	examiner?	lospital:	Other					pecify) Hospice	
	ading Phys th. : After this funeral di	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Work?							
	or Attendation after death		3 Suicide 6 Could not be 4 Homicide determined	286. Place of injury - At home, farm, street, factory, office				Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	edical C	29a. Certifier (Check only one) Check only one) (Check only one)								
	o the	Me	29h Sinnature and title of certifier MGD (CA), DIRECTOR 29c License number						29d. Date signed (Mpnth, Dey, Year)		
)	->-0		Gir, I f. II hp. Hostice D10587						2/17/2004		
	5		30. Name and address of person who co	empleted cause of de	ath (Item 23a) (Type,			CT66 14	,	prederick co	
			GEORGE 1. SMITT	. 1	516	TRAIL	AUE !			D: 21701	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	's Signature	1.11.					
	Registi	ar	EER 1 9 20	10/1	K 4						

State of Maryland / Department of Health and Mental Hygiene 2004 For State Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 11,2004 **Physician** 1415 Mildred Schnaitman Kacher /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Talbot Memorial Hospital Easton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Min. 1 □ M 3 F 212-05-3536 Director 87 8-21-1916 St.Michaels, Usual Residence of Decedent the Maryland 10a. State 10d. In City Limits 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examinar must be notified at 1√ Yes 2 No Director MD Talbot St. Michaels 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code ō 304 Manor Street or itema 23a 21663 USA Funerai kacher, Mildred Maryland 21215-0036 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 ☐ No Yes, Give X 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No 2 3 ₩ Widowed 4 Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "na any injury or other traumatic event, tra Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 11 years
17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be John Schnaitman Ruby Straughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 1984, St. Michaels, MD. 21663 Date 20c. Location - City or Town, State Russel Kacher (son)
20a. Method of Disposition Baltimore, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 2-12-04 Dover, DE 21. Signature of Funeral Service Licensee R. Carroll Hurley Funeral Home, PC. 1. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode Peying, Subhascada of the death and the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) physician Physiclan/Medical use as the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No I or Attending Physician: after death. Diractor: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ပို 1 Inpatient 2 ER/Outpatient 3□ DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lakshmi Vaidyanathan, MD. 219 S. Washington St. Easton, MD. 21601
31. Date filed (Month. Day Year) 32. Registrar's Signature
FEB 17 2004 State Registrar

DHMH 17 Rev 1/2001

S

Box 68760

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 23, 2004 **Physician** MILTON STANLEY KRAUSE 5:45 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LA PLATA CIVISTA MEDICAL CENTER CHARLES If Under 1 Year If Under 24 Hrs. Months Days Hours Min. JULY 12, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□F Yrs. 216-18-6360 78 Director 1925 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes ZNO Director MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 7015 EVERGREEN DRIVE or items 23a 20601 UNITED STATES Funerai 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No 194
If Yes, Give 1 94 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1942 within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 1946 Specify: δ 3 XWidowed 4 ☐ Divorced "naturai", WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 12 POST OFFICE MANAGER U.S. POSTAL SERVICE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental 1 and 2 should be ie marked MILTON STEPHEN KRAUSE MARY E. KULIS 19a. Informant's Name/Relationship (Type, Print)
BROTHERitem 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 RICHARD N. HARMEL -IN-LAW 14141 SPRING BRANCH DRIVE, UPPER MARLBORO, MD 20a. Method of Disposition
11 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) MARCH 20c. Location - City or Town, Stete Pages ō I permit. Page Department of important: If any injury or once. MD VETERANS CEM. 3, 2004 * 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND MGBn turn of Funeral Service M00053 22. Name and Address of Facility H. Hokaum HUNTT FUNERAL HOME, P.O.BOX 156, WALDORF, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 physician Physician/Medical as the attending a IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2€No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 20 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1x Inpatient 2 ER/Outpatient 2 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: within 24 hours after use....
To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 052289 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NALIN MATHUR, MD, 10 ST. PATRICKS DRIVE #404, WALDORF, MARYLAND 20603 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 2 5 2004

			1_ For		yland / Dep	artment of Health a	•	aiene	04 07681
			Registrar		Ce	ertificate of Death		rieg. No.	
į	Physici /Medic		Decedent's Name (First, Middle, Last)		ae Klipstein		2. Date of De Month Februs	Day	Yeer 3. Time of Death
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or Location of		4c. County	
			SACRED HE	HRT		CUMBERI	~AND		e GANY
	Funeral Director		5. Social Security Number 6. Security Number 219-52-0147	7. Age (i	In yrs. last birthday 55 Yrs.	y If Under 1 Year If Under 2 Months Days Hours	Min. (Month, Da	th ly, Year) e 13, 1948	Birthplece (State or Foreign Country) Mary land
	P >		Usual Residence of Decedent 10a, State 10b, County	1	0c. City, Town or L	ocation			10d. Inside City Limits
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Hygiene marked other than "natural", or items 28a or 28e-f ahow marked other than "natural", or items 28a or 28e-f ahow matic avent, the Modical Examiner must be notified at	ctor		legany	oc. City, Town of E	Frost	burg		1 XYes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of W	hat Country?
	ath w			neysuckle Lane		215			USA
	er de Itams	Funeral	TI Maria States	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.))- 14. Race Black	- American Indian, r, White, etc.
036	ours aft	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 😿 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:		Specify:	White
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece (Give	edent's Usual Occupation a kind of work done during most DO NOT use retired)	of working	16b. Kind of Bus	siness/Industry
21215-0036	within iene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ше.	Retai			Management
<u> </u>	Hygi other	BeC	17. Father's Name (First, Middle, Last)			18. Mother	's Name (First, Middle,	, Maiden Sumame	
Maryland	should be nd Mental i marked c	To B	(Blenn Clem Rite	chie		D	olores Mon	ahan
lan.	2 2 2 3		19a. Informant's Name/Relationship (Ty		19b. Mail	ing Address (Street and Number			
	s 1 and f Health item 27 other to		James Robert Kli 20a. Method of Disposition		20b. Place of Disp	15701 Lower Georg	es Creek Road		coning,Md. 21539 Dity or Town, State
Jor	Pages nent of P int: if its iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State		osition (Name of practory or other place)	February 1	,	
Baltimore,	permit. Pages Department of Important: If II any injury or (once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	90		tburg Memorial Park 2. Name and Address of Facility	2004	Fro	stburg, Maryland
Ba	Dep		Jas & Make	Q		Eichhorn-M	McKenzie Fune		
	14		23a. Part1. Enter the disease, or compli	cations that caused the	e death. Do not en	iter the mode of dying, such as c	St.,Lonaconir ardiac or respiratory ar	ng,Md,21539 rrest,	Approximate Interval Between
Ė	nysician		Immediate Cause (Final disease or condition		stage C	hornic obstr	uctive Im	ne Disea	
	/Medical Examiner		resulting in death)	Due to (or as a c			*****	0	Omorning
	LXUIIIIIIEI		Sequentially list conditions,). Due to for as a c	reservation of				
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	220 10 (01 40 4 0	onsoquence ory.				
ó	ate be executed nysician and he burial-transit		that initiated events cresulting in death) Last	Due to (or as a c	consequence of):				
	ate be nysicia he bu	licai		J					
89 2	leath certificat attending phy I for use as the	Med	IF FEMALE:		- 37				10 - W
Вох	ath co	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of particle 1 ☐ Live birth 2 [4 ☐ Pregnant at time	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date Mon	of delivery th Day Year
о. О	the de	Physician/Med	1 ☐ Yes 2 🔏 No 9 ☐ Unknown	9□ Unknown	ie Oi Geath 5t				
ري ت	ires that the de signed by the a I be detached f	by Pt	Part II. Other significant conditions con				23e. Did to	obacco usa contri	bute to the cause of death?
rds	w require been sig should b		Congestive	Heurt	Failu	re	101	Yes 2□No 3	3 ☐ Probably 4 🏋 Unknown
ecc	e iaw re has be ge 2 sh	Completed					24a. Was	osv pr	ere autopsy findings available ior to completion of cause of
I E	Physicien: The la rr this certificate have and director, page 2	Con					perfo 1 ☐ Yes	rmed? de	ath? ☐Yes 2☐No
Vital Records,	alcien certifi rector	Be	25. Was case referred to medical examiner?	lospital:		Other	of Death (Check only o		
<u></u>	Phys rr this aral di	: To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Injury	28b. Time o	THE SELECT 4 INUIS	sing Home 5 Resident	dence 6 Dother	
lo lo	Atlanding Physicien: The law requires that the death certifical death. ecteath. ecters Alter this certificate has been signed by the atlending phy the funeral director, page 2 should be detached for use as the	atior	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Y	ear) Injury	Work? M 1 ☐ Yes 2 ☐ N		,,,,	
Division of	or Atta after des Directo in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, st (Specify)	reet, factory, office	28f. Location (S City or Tox	Street and Number vn. State)	r or Rural Route Number,
_	To the Hospitel or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the to		(Check only 2 Medicel Exemin	sician: To the best of n	ny knowledge, deat ramination and/or in	th occurred at the time, date and ovestigation, in my opinion, death	place, and due to the	cause(s) and man	ner as stated.
	thin 2 o the l	Medical	29b. Signature and title of certifier	and manner stated	d.	29c. License number			(Month, Day, Year)
	F 3 F 8		Work Shr	MD		000 5532		Feb 15	
	6		000000						,
	5		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type,	, Print)	100 1000		
2	5 1 LS		30. Name and address of person who co WONSOCK SHIN I 31. Date filed (Month, Day, Year)		m Terro	- 1	9 MD 215	32_	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07682 State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year KAMBER **Physician** 17=58PM 15 2004 62 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner RONTGORERY Marshel 5. Social Security Number OLUEV UU If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** 1**★** M 2 □ F 8 11/20/1922 Washington, Director 578-18-2779 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ahow other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Bethesda Maryland Montgomery Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 7420 Westlake Terrace #409 20817 United States of America deeth Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Army If Yes, Give Unknown Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Items filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: White 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. United States Elementary/Secondary (0-12) College (1-4or 5+) Government Accountant other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Pages 1 and 2 should be in nent of Health and Mental 1 and: If Itam 27 is marked o Max Kamber Fannie Kline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Kamber - Wife #409, Bethesda, MD 20817 7420 Westlake Terrace 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State portant: If It 1 ▼Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Judean Memorial Garden 02/18/04 Olney, Maryland 21. Signature of Funeral Service Licenses . Name and Address of Facility Danzansky Goldberg Memorial Chapel, Inc. 1170 Rockville Pike, Rockville, MD 20852 Depart Impor any in 1 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician PINEUDONIA ASPIRATION 48h resulting in death) /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No detached 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, page 2 should be 2 🗷 No 3 Probably 4 Unknown 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 1 Tes 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☑Inpatient 2 ☐ ER/Outpatient Certification: To 3□ DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter Injury 1 Naturai 5 Pending s after death. М 1 □ Yes 2 □ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by t 4 Homicide within 24 hours at To the Funeral D completely filled in the Hospital I 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02/15/2004

State Registrar

4301

ROSEPAUL 31. Date filed (Month, Day, Year) FEB 1 7 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bethesda 32. Registrar's Signature

20814 souls

D0060964

SCHREMMER

BRUNG

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Ce	rtificate of	Death	1	Reg. No. 20	104	0768
			1. Decedent's Name (First, Middle, La	st)				2. Date of De.		Year	3. Time of Death
	Physici /Medic		Miriam	K	AYE			Februar		004	2:30a M
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Death		4c. County of	of Death	
			Suburban Hospita	1		Bethe			Mont	gomer	у
	Funeral		5. Social Security Number 6. S 577-22-0466	ex 7. Ag ☐ M 2XX F	e (In yrs. last birthday) Q 2 Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da	th y, Year)		ace (State or Foreign try)
	Director		Usual Residence of Decedent		83 Yrs.			Nov. 29	9, 1920	Mary	land
	land w		10a. State 10b. County		10c. City, Town or Lo	ocation				10	Od. Inside City Limits
	Mary -i-eh	ţō	MD Montgome:	ry	Silver S	pring					1 ☐ Yes 2X No
	r 288	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Coun	try?
	h with	<u></u>	3330 North Leisur	e World Bl	vd. # 521	2090	6		U.S.	. A .	
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		- America	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. by other than "naturel", or Itema 23s or 28s-1 show event, the Middical Exeminer must be notified at	by Funeral Director	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X	No	1 ☐ Yes 2 💢 No		rican, etc.)	Specify:	, White, e	White
Ö	2 hou	Completed	15. Decedent's E		16a. Dece	dent's Usual Occu	pation		16b. Kind of Bus	siness/Ind	ustry
215	hin 7	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	life.	NOT use retire	during most of work ad)	ang	0 11-		
2	od with) LO	12			memaker	,		Own Ho	me	
Q	be filed tal Hygid d other	Be (17. Father's Name (First, Middle, Last,				18. Mother's Nam	e (First, Middle,	Maiden Surname	1)	
la	Mental Mental arked c	To	Charle	s Shelt			Sara		Millison		
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic evonce.	1	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street	and Number or Rui	ral Route Numbe	er, City or Town, S	itate, Zip	Code) 2090.6
2,5	and ealth m 27	15	alph Kaye / spo	ouse 		111111111111111111111111111111111111111					Spring, M
Ore	Fite P		20a. Method of Disposition 1 XXurial 2 Cremation 3	Removal from State		natory or other pla	ice)	Date	20c. Location - C	ity or Tov	wn, State
Ë	ment cant: If		'4 □Donation 5 □ Other (Specif				ery 2/16/		Adelphi,		
Baltimore,	epart epart nport ny in		21. Signature of Funeral Service Lices	isaa /	T	Name and Addre	ess of Facility Hebrew I	Tuneral	Home, In	c. 2	54 Carroll
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	I the death. Do not en ne.	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	. SEVER	LE CHROI	vic obs	MUCTIVE	PULLMOR	VARY DIS	EXE	Onset and Death
*	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
В		-	Sequentially list conditions, if any, leading to immediate	b.	à consequence of).						
	ed isit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence on.						
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×	death certificate b attending physic d for use as the b	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date	of deliver	v
Bo	that the death cer ed by the attendin detached for use	Physician	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		Mont		Day Year
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00	s been s s been s	Completed	BARKINSON'S D	ISGASE			,	24a. Was		ere autop	sy findings available
Re	The law ate has page 2	E		•					med? de	ior to com eath? □ Yes 2	pletion of cause of
ital		0	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes	7	1185 2	20 140
\leq	S S	To B	examiner? 1 ☐ Yes 2 No	Hospital:	int 2 ER/Outpatier	it 3 DOA Ott	200		lence 6 Other	(Specify))
0			27. Manner of Death	28a. Date of Inju	y Year) 28b. Time o	28c. Inju	ry at	28d. Describe h	ow injury occurred	d	
jo	Attending ir death. ctor: After by the fune	atto	1 Natural 5 Pending 2 Accident investigation	1	, , , , , , , , , , , , , , , , , , , ,		Yes 2 □ No				
Division	l or Attendate after death Director:	ertification:	3 Suicide 6 Could not b	28e. Place of Injuding, etc	ury - At home, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number m, State)	or Rurai	Route Number,
	italo rsaft raiDi	O								2100	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exar	ysician: To the best on the basis of	of my knowledge, deat examination and/or in	occurred at the til	me, date and place, opinion, death occur	and due to the o	ause(s) and man	ner as sta	ited. the cause(s)
	the hin 2- the tree mplet	Med	one)	and manner sta	ited.						
	wit To		29b. Signature and title of certifier	·\$1 = :		29c. Licens	6571	2	29d. Date signed	Month, D	ray, real)
7	0		Man	yus -		02	-U3 TI		4/14	104	-
	*		30. Name and indess if person who	ompleted cause of d	eath (Item 23a) (Type, 1215 FERN	Print) /WOOA A	の 神401	BETHE	SOA, M	0)	2817
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	/					0011
in the second	Registr	_			was 19	poort	1				

2:30 Am

KAYE, MIRIAM . 2/14/04

			1 - State	State of Marylar	nd / De		nt of H	ealth a		ntal Hyg	giene	200	4 07684
			Registrar 1. Decedent's Name (First, Middle, Las	e)			ie oi L	Jeani	2	Date of Dea	Reg. No.		3. Time of Death
	Physici	an		. ,						Month	Day		
	/Medic		Klaus Georg Ko			41- 01-	T	1		'ebruar		2, 2004 County of Dea	
	Examin	er	4a. Facility Name (If not institution, give				_	Location of					
			2701 Shanandale 5. Social Security Number 6. Secur		lact hirth			Spri		Data of Birth		Montgo	
	Funeral			⊠M 2∏F	Yı	Months		Hours	Min.	. Date of Birth (Month, Day	, Year)	9. 6	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	67					A	pril 1	1, 19	136 Ge	rmany
	land ow		10a. State 10b. County	10c. C	ity, Town	or Location							10d. Inside City Limits
	Mary	to	Maryland Montgo	merv	C 1 1	ver Sp	ring						1 ☐ Yes 2 🖾 No
	28a	Director	10e. Street and Number	incly	<u> </u>		ip Code			-	10g. Citi	zen of What C	ountry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-f ehow ont, the Medical Examinar must be notified at	0	2701 Shanandale	Drivo			2090	1.				US	2 A
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S.	13. Was Dec			in? (Specif	y Yes or No- can, etc.)		14. Race - Am	erican Indian,
20	r Iter	Ē	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 ☑ No					, Puerto Rio	can, etc.)		Black, Whi	
ä	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	21X No	Specify:				Specify: Wh:	ite
Ŏ	2 ho	Completed	15. Decedent's Ed		16a. D	ecedent's Us	ual Occupa	tion	-1		16b. Ki	nd of Business	s/Industry
2	Med "	pie	(Specify only highest gra	College (1-4or 5+)	- '7	Give kind of wife. DO NOT	use retired)	aring most	UI WOIKING				
2	gien gien	М		5+	P	hysici	st				U.	S. Mil:	itary
g	be filed stal Hygi ad other avent, I	Be (17. Father's Name (First, Middle, Last)					18. Mother	r's Name (F	First, Middle,	Maiden	Sumame)	
Ja	uld b Venta	To	Wolfram Kerr	is				Hed	lwig k	Keil			
Maryland 21215-0036	2 sho and I is me		19a. Informant's Name/Relationship (7	Type, Print)	19b. l	Mailing Addre	s (Street a				r, City o	r Town, State,	Zip Code)
	1 and 2 Health em 27 i		Paula Kerris/ Wi	fe	270	1 Shan	anda1	e Dri	ive, S	Silver	Spr	ing, MD	20904
ore.	f item		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐		Place of D cemetery,	isposition (National Communication)	ame of other place) F	ebrua	rv 17	20c. Lo	cation - City or	Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow amounts in your or other traumatic avent, the Wedical Examinar must be notified at once.		`4 □ Donation 5 □ Other (Specify		ropo	litan (Cremat		200		Alex	andria	, Virginia
a	permit. Departr Importa any inju		21. Signature of Funeral Service Licen	see		Franci	nd Addres	s of Facility	ns Fr			e Inc.	
m	89 = 8		Brodley J &m	refer		500 Un	ivers	ity B	31vd.	W., S:	ilve	r Sprin	ng,MD 20901
В			23a. Part1. Enter the disease, or company shock, or heart failure. List only	ocations that caused the dea	th. Do no								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Bladder Car	rcino	ma							Onset and Death
	/Medical		resulting in death)	Due to (or as a conse									2 years
В	Examiner		Construction of the line and distance	b									
Щ		ner	Sequentially list conditions, any, leading to include a cause. Enter Underlying	Due to for as a conse	quenca of								
	cuted nd ransi	Examiner	that initiated events	c									
Ó	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of	:							
3760,	ys	Icai		d									
9	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE:								-		
ŏ	th ce lendii r use	an/	23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		3 □Ectopic	oregnancy				2	23d. Date of de	
B	dea of fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of a		5 Other (s						Month	Day Year
0	at the by the	J.	9 ☐ Unknown	3LI OTRITOWIT									
	The law requires that the death certifica Ite has been signed by the attending ph page 2 should be detached for use as the	by F	Part II. Other significant conditions of	ontributing to death but not re-	sulting in t	he underlying	cause give	n in Part I.		23a. Did to	bacco u	se contribute t	o the cause of death?
Records,	w requires to been signer should be	ed								1 🗆 Y	es 2	⊠No 3∏P	robably 4 DUnknown
သူ	law re as be 2 sho	Completed								24a. Was a		24b. Were a	utopsy findings available completion of cause of
Œ	The Tate has page	ē								perfor	med?	death?	s 2 No
Vital	ician: Th certificate ector, pag	Bec	25. Was case referred to medical					26. Place	of Death (C	Check only or			
	Physician: this certific ral director.	ToE	examiner? 1 Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outp	atient 3 🗆 🗅	OA Othe	4 Nur	sing Home	5 🖾 Resid	ence 6	6 □Other (Spe	ecify)
0			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tin		28c. Injury Work	at ?	280	d. Describe h	ow injun	y occurred	
<u>o</u>	Attending ir death. ector: Aftei by the fune	atic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		,	м		es 2□N	ło				
Division of	# 0 0 ×	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Speci	ome, fam	street, facto	ry, office		28f	Location (S City or Tow			ural Route Number,
	tel or rs afte al Dir ed in	Certification:							T		, 3,410)		
	ospil hour uner		29a. Certifier S Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kn	owledge,	death occurre	at the time	e, date and	place, and	d due to the c	ause(s)	and manner a	s stated.
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	one)	niner: On the basis of examination and manner stated.	ation and/	ur irivestigatio	n, in my op	mion, death	occurred				
	To t To t	Σ	296. Signature and title of Certifier			29	c. License			2	9d. Date	e signed (Mon	th, Day, Year)
)	8		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	` '		[D0051	L946		:	Febr	uary 1	2, 2004
	3		30. Name and address of person who	completed cause of death (Ite	m 23a) (T	ype, Print)							
_			Roberto Pili M.D.	401 N. Broa	dway.	Balti	more.	MD 2	21205				
	Sta Registr		31. Date filed (Month, Day, Year) FFR 1 8 20	32. Apistrar's Sign	ature	1	racks						
100	TI STORY	10		11.14	/ 4	100	~ ~~ <u>~</u>	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 07685 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 16, 2004 **Physician** Genola D. Kolp 6:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Manor Care-Silver Spring Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖺 F 93 326-18-0235 Illinois Director January 6, 1911 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits in than "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2501 Musgrove Road 20904 United States filed within 72 hours after death within 72 hours after death other than "natural", or Iteme 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Grocery Store other permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: If them 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Schumann Ella Graf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul W. Kolp / Son 6527 East Halbert Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete February 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Ridge Cemetery 21, 2004 Hillside, Illinois 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1 Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final Alzheimer's Disease **Physician** Years disease of condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Rheumatoid Arthritis, Atrial Fibrillation 1 Yes 24 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 \(\overline{\Omega} \) No certificate has 1□ Yes 1 ☐ Yes 2 ☐ No Physicien: 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide after within 24 hours a To the Funeral D 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) P. 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Dev. Year) D56797 2 February 16, 2004

Registrar DHMH 17 Rev 1/2001

State

13952 Baltimore Avenue, Laurel, Maryland 20707

Looks

32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lalitha Tadikonda, M.D.

FEB 1 9 2004

31. Date filed (Month,

		1 - For State Registrar			artment of Hea rtificate of De		Reg. No. 200	4 0768
Physicia	an	1. Decedent's Name (First, Middle,	Last)			2. Date of Month		3. Time of Deat
/Medic	al	Dorothy K			T	Febru	ary 9, 2004	9:35 A
Examin	er	4a. Facility Name (If not institution,			4b. City, Town, or Loc	ation of Death	4c. County of D	
Funeral		Suburban Hospit 5. Sociat Security Number	6. Sex 7. Ag	e (In yrs. last birthday)		Under 24 Hrs. 8. Date of	Montgo	nery Birthplace (State or For Country)
Director		091-07-9659	1 □ M 2 💢 F	90 Yrs.	Months Days H	ours Min. (Monti		W York
and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Li
Manyli f sho	tor							1 K]Yes 2[
n the	lrec	Maryland Montgo	щегу	Bethesda	10f. Zip Code		10g. Citizen of What	Country?
within 72 hours after death with the Maryland ene. Than "natural", or Itams 23a or 28a-f show the Maryled Exerting the natified at	Funerai Director	7505 Democracy	Blvd. #217		20817		U.S.A	•
er dez	une	11. Marital Status	12. Was Decedent I Armed Forces?		Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify Yes o lexican, Puerto Rican, etc	or No- 14. Race - A Black, W	merican tndian, hite, etc.
rs afte	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 [X] N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 ☒ No S	pecify:	Specify: W	nite
72 hours natural;	ted	15. Decedent's	s Education	16a. Dece	dent's Usual Occupation		16b. Kind of Busine	ss/Industry
be filed within 72 ho ital Hygiene. Id other than "netu svent, Itse Miculcal	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	life	kind of work done durin DO NOT use retired)	g most of working		
filed with the street	Con	AT Publish Name (Pina Address I	5+	Scient	tific Edito		Publishi	ng
ntal H ed ot	Be	17. Father's Name (First, Middle, L	ast)		18.	Mother's Name (First, Mi	iddle, Maiden Sumame)	
2 should be filed within and Mental Hygiene. Is marked other than eumatic event, II a M	To	Walter Skinner 19a. Informant's Name/Relationshi	ip (Type, Print)	19b. Maili	ng Address (Street and	Flora Gelde	rmann umber, City or Town, State	a Zio Code)
nd 2 alth ar alth ar 27 ls		Morton Katz-Hu					thesda,MD 20	
permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiest III important: If item 27 is marked other than "natural", or any injury or other treumatic event, the Michigal Exercit		20a. Method of Disposition	2 🗆 🗆 🗆	20b. Place of Dispo	osition (Name of matory or other place)	Date	20c. Location - City	or Town, Stete
Pages ment of ant: If its		1 Donation 5 ☐ Other (Sp.		Judean Me	em. Gar.		Olney, MD	
ermit. Pepart nport ny inj		21. Signature of Funeral Service L	C \$600			Facility Hines-Ri		
4 00 5 4 Q		23a. Parti. Enter the disease, of c shoet, or heart failure. List o	felt .				Silver Spr	ing, MD 20
ate be executed white burial-transit the burial-tra	dicai Examiner	5 yearlally let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronar Due to (or as: Adatic	a consequence of): ry Artery [a consequence of): Valvular S a consequence of):				
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. it yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of o	delivery Day Yea
Physician: The law requires that this certificate has been signed by ral director, page 2 should be detailed.	ρ	Part II. Other significant condition Acute Rena	ns contributing to death bu 1 Insufficer	-	nderlying cause given in		Did tobacco use contribute 1 □ Yes ② No 3 □	
s bee	Completed	Pneumonia					Was an 24b. Were	autopsy findings ava
The law ate has page 2 :	mo						performed? death	o completion of cause ? es 2 No
ician: Th	BeC	25. Was case referred to medical examiner?				Place of Death (Check o	nly one)	
Physic this or	2	1 ☐ Yes 2 🙀 No	Hospital:		nt 3 DOA Other: 4		Residence 6 Other (S)	pecify)
ding P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		y Year) 28b. Time o Intury	f 28c. Injury at Work? M 1 ☐ Yes		ribe how injury occurred	
	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be	iry - At home, farm, str (Specify)		28t. Locati	on (Street and Number or Town, State)	Rural Route Number
I or Attending after death. I Director: After d in by the fune	er		Physician: To the best of	ot my knowledge, deat	h occurred at the time, di	ate and place, and due to	the cause(s) and manner	as stated.
Hospital or Attend 124 hours after death Funerel Director:		29a. Certifier (Check only one) 1 Certifying 2 Medical E	xaminer: On the basis of and manner sta	ted.	vostigation, in my opinion	i, death occurred at the ti	,	ue to the cause(s)
To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical Cert	(Uneck only 2 Medical E	xaminer: On the basis of and manner sta	ted.	29c. License nur		29d. Date signed (Mo	
the Hospi in 24 hou the Funer npietely fill		(Check only 2 Medical E	xaminer: On the basis of	ted.				nth, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ROBERT LEE KERILL ĺ5, February 2004 6:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□ F 220-54-2412 Director 52 1951 Washington, D.C. 18, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or then "natural", or items 23a or 28a-f show the Medical Examinar must be mutified at 1X Yes 2 □ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10921 Inwood Avenue, Apt #334 20902 II.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 2 / 27 / 1970 1 ØYes 2 □ No CO 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:3/9/1973 1 ☐ Yes 21 No Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) i. Pages 1 and 2 should be filled to transit of Health and Mental Hygies and I flam 27 is marked other thing yor other traumatic event, the Contractor Home Improvements 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Kerill Robin Payne ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Lynn Brannan/Sister 9907 Woodland Drive, Silver Spring, Maryland 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If sny injury or Quantico National Ceme. 2/28/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Triangle, Virginia 22 Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses once. 20904 Nancu ance 11800 New Hampshire Avenue, Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Atherosclerotic Cardiovascular Disease Months resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical as the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy jo Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached o the 9 Unknown 9 Unknown ģ م signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by pe 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 🔯 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Hospital: 1 🗌 Inpatient 1 Yes 2 No 2 ☑ ER/Outpatient 3 ☐ DOA this npletely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: after death. Diractor: After 5 Pending investigation 1 🕅 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 within 24 hours a To the Funeral L Hospital Medical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 D - 50678 February 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rafeu Bafra, 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) State 32. Registrar's Signature FEB 23 Registrar 2004

State of Maryland / Department of Health and Mental Hygiene 2004 07688

				Certificate	of Death	Я	leg. No.	0 4 0 7 0 8 6
	Dhomisian	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th Day Ye	3. Time of Death
	Physician /Medical	Ki Yun Kim				Februa		04 3:45 AM
	Examiner	4e Fecility Neme (If not institution, give	•		4b. City, Town, or	Location of Deeth	4c. County of D	eeth
		Randolph Hills Nu:			Silve	r Spring		omery
	Funeral	5. Social Security Number 6. Se	THE OFFICE	Months	Year If Under 24 Hr Deys Hours Mir		Year) 9.1	Birthplece (State or Foreign Country)
	Director	220-00-2312	3K F 84	Yrs.		Feb. 20	, 1919 K	orea
	pue *	Usuel Residence of Decedent 10a. Stete 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Limits
	Maryl feho	Maryland Montgome						1 ☐ Yes 2 ☑ No
	with the Man or 28a-febractor	10e. Street end Number	=1y 51.	lver Spring	ode	1	0g. Citizen of Whet	Country?
	3a or	14204 Cribbage Ten	race	209			Korea	
	r items 23s niner must Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	,S. 13. Was Decede	nt of Hispenic Origin? (y Cuban, Mexican, Pue	Specify Yes or No-		merican Indian,
21215-0020	by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		No Specify:	no moan, etc.)	Black, W	Asian
5	led within 72 ho lygiane. Nor than *nature it, me Medical is Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's Usual (Give kind of work	Occupetion done during most of we	orkina	16b. Kind of Busine	ss/Industry
12	ithin ne.	Elementary/Secondary (0-12)	College (1-4or 5+)		done during most of we retired)			
2	Per state	8		Homem		(5)	Own	Home
S E	Se se de la	17. Fether's Neme (First, Middle, Last) unknown				ım <i>e (First, Middl</i> e, I	Maiden Sumame)	
$\frac{8}{5}$	Men					cnown		
Maryland	l 2 st h and la m rraum	19e. Informent's Name/Relationship (Ty		19b. Mailing Address (
e,	1 and Healt Im 27	Jong Kim - Grandso 20e. Method of Disposition		3915 Harva	ard Street,	Silver	Spring, M 20c. Location - City	D 20906
Baltimore,	Pages ment of I	1X Burial 2 □ Cremetion 3 □ F 4 □ Donation 5 □ Other (Specify)	C	te of Heaven	er place)			
ga	permit. Pages Department of Important: if it any injury or once.	21. Signature of Fune of Service License	Putin					al Home, Inc. ing, MD 20904
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ations that caused the deat	7				Approximate
	Physician	snock, or neart tallure. List only or	ie cause on each line.					Interval Between Onset and Death
	/Medical	Immediate Cause (Final	Acuta Tub	ılar Necrosis	_			2
	Examiner	diseese or condition resulting in death)	J	or as a consequence of):	5			2 weeks
	je je		546 10 (0	as a consequence or,				;
	ficete be executed physician end as the buriel-transit edical Examiner	Sequentially list conditions)Due to (c	or es a consequence of):				
Ď.	an er	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying						
58/50,	ate by hysic he bi	Ceuse (Disease or injury that initiated events resulting in deeth) Last	Due to (o	r as e consequence of):				
ŏ ×	eath certificate be executed attending physician end for use as the buriel-transit clan/Medical Examir							1
o n	ath ce trend or us							
-	nat tha death con the attend of by the attend fet us letached for us Physician	Part II. Other significant conditions con	tributing to death but not resi	ulting in the underlying cau	se given in Part I.	23b. Did to	bacco use contribi	ite to the cause of death?
г Э	requires that the death c seen signed by the attend should be detached for us eted by Physician.	Septicemia, Diabe	tes Mellitus,	Dementia,		1 □ Y	s 2 XNo 3 □	Probably 4 Unknown
Š	ras the signed to be of the of							
5	stan: The law require artificate hes been sixotor, page 2 should the Completed I	Senile Inanition				24a. Was a		b. Were autopsy findings available prior to completion of cause
9	aw 2 2 2							of death?
=	Se per Se Co					1LJYe	5 2LX140	1 🗆 Yes 2 🗀 No
		25. Was case referred to medical examiner?				ath (Check only on	9)	
5	hysic his o	1 165 24E NO		ER/Outpatient 3□ DOA			nce 6 Other (S	pecify)
5	Ing P	27. Manner of Deeth 1 X Natural 5 □ Pending	28e. Date of Injury (Month, Dey Year)		. Injury et Work?	28d. Describe ho	w injury occurred	
2	Attending or death. ector: After by the fune ification.	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	tal or Attending P rs aftar death. al Director: After t led in by the funere Certification:	4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		office	28f. Location (St.		Rurel Route Number,
_	pltal	20a Cartifica	I de la companya de l	de de la desta	the desired			2004
	To the Hospital or Attentwithin 24 hours after deal To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier	sician: To the best of my knowner: On the basis of examinat and manner stated.	wieage, aeeth occurred et tion and/or investigation, in	me time, date end place my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner ate and place, and d	as steted. lue to the cause(s)
	within 2 To the comple	29b. Signature end title of certifier	and marrier stated.	29c. L	icense number	25	3d. Date signed (Mo	onth, Dey, Yeer)
	F ₹ F 8	M	5		D08944			19, 2004
		or Newton	o may (1)	,			TOTUALY	17, 2004
		30. Name end eddress of person who co	U		A T7		D 0000=	
, I		Martin L. Shar 31. Date filed (Month, Day, Year)	gel, M.D. 3/	20 Farragut	Ave., Kens	ington, M	D 20895	
	State Registrar	FEB 2 3 200	4 Janera	& Som	Ks/			

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

2 4 2004

32. Registrar's Signature

	•	For State Registrar	State of Maryland / Dep		Mental Hygie	
		Decedent's Name (First, Middle, Last,			2. Date of Death	3. Time of Death
Physicia /Medic Examin	al	Jung Gyo Kwon 4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea		Day Year 18, 2004 3:00 P 4c. County of Death
		5801 Nicholson Ln		Rockville		Montgomery
Funeral Director		5. Social Security Number 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthda M 2XIF 60 Yrs.	y) If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthplace (State or Forei Country) 1943 Korea
р. "		Usuel Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location	Dec.10,	10d. Inside City Limit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Department: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury of other traumatic event, the Modical Examinar must be notified a once.	ector	Maryland Montgom		11e	10-	1 □ Yes 2 ½ N
with t	2			10f. Zip Code	109.	Citizen of What Country?
leath	era	5801 Nicholson Ln 11 Marital Status		20852 3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	Korea 14. Race - American Indian,
urs after o	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puè 1 ☐ Yes 2 No Specify:	rto Rican, etc.)	Black, White, etc. Specify: Asian
d within 72 hours aff giene. or than "natural", or i. he wodeal Evern	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad	e completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wo . DO NOT use retired)	orking 16	b. Kind of Business/Industry
d with giene er the	mo.	12		omemaker		Own Home
buld be filed with Mental Hygiene arked other tha	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Mai	iden Sumame)
d 2 should be file th and Mental Hy 17 is marked oth traumatic event	To	Sunghee Choi		Soo	Kwak	
and ls mu		19a. Informant's Name/Relationship (T)	rpe, Print) 19b. Ma	illing Address (Street and Number or F	Rural Route Number, C	ity or Town, State, Zip Code)
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		Sung D. Kwon/Husb		1 Nicholson Ln, R		
Definit. Pages 1 a Department of Hez mportant: If Item any injury of othe		20a. Method of Disposition 1 Burial 2X Cremation 3 F		position (Name of rematory or other place)	Date 20d	c. Location - City or Town, State
Pag ant:		* 4 □ Donation 5 □ Other (Specify)		ncoln Crematory F	eb 23, 200	4 Brentwood, MD
permit. Departi Import any inj		21. Signature of Funeral Service Licens	1117	22. Name and Address of FacilityHi		
207 # 9		Mohau (e	ications that caused the death. Do not ene cause on each line.			lver Spring, MD 209
Certificate be executed Additional and asset the burial-transit The ass the burial-transit The asset the burial-transit Th	cal Examiner	disease or condition resulting in death) Sequentially list conditions, the property of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Zaroma		
artificate be exing physician are as the burial.		IF FEMALE:				
death e atter	Completed by Physiclan/Medl	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B Ectopic pregnancy C Other (specify)		23d. Date of delivery Month Day Year
Se Ge	d by Pl	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Unknow
he law requir e has been si age 2 should	mplete				24a. Was an autopsy performer	24b. Were autopsy findings availab prior to completion of cause of death?
Physician: The law requires t this certilicate has been signe ral director, page 2 should be o	Ö	25. Was case referred to medical		26 Place of De	1 ☐ Yes 24 eath (Check only one)	No 1 Yes 2 No
Physician: this certific ral director,	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Total Control of the		e 6 ☐Other (Specify)
ng ffei		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stree City or Town, S	nt and Number or Rural Route Number, State)
e Hospiti 24 hours e Funera letely fille	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred to the contract of the c	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier	Ωl >	29c. License number D52767		Date signed (Month, Day, Year)
10			ompleted cause of death (Item 23a) (Typ			b. 20, 2004
			M.D. 50 West Edmor	ston Rd. Suite 30	3 Kockvill	e, MD
Sta Registr		31. Date filed (Month, Day, Year) FFR 2 3 200	32. Registrar's Signature	Sports		

State of Maryland / Department of Health and Mental Hygiene 2004 07691 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** RUKMINI February 12, 2004 KHAN 1:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Annapolis Anne Arundel Medical Center Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 28, 1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F 74 Yrs 214-59-5127 India Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer near be notified at 1 ☐ Yes 2 ☑ No Crofton Maryland Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23s or 21114 2530 Chelmsford Drive India Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Middical Examinat ODEs. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Asian þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Medical Doctor Medical/ Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Unknown) Subhadra Narasimham Seelum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2530 Chelmsford Dr., Crofton, Md. 21114 Aziza Meer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) February 14 Beltsville, Md. Chesapeake Crematory 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral and Cremation Services a Stronly -Maz61 933 Gist Ave., Silver Spring, Md. 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ADRTIC ANEURYS'M Immediate Cause (Final disease or condition resulting in death) RUPTURED **Physician** /Medical CARDIOVASCULAR DISEASE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physicien and d in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3
Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 41417 ANN APOLIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKWAY, SUITE 520 L-K. ESSANDOH, MD MEDICAL 2002 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 1 8 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			Please	e Type or Pri State of M				. Ensure A lealth and N		_	le.
			1 - For Stete Registrar	Otate of 14	iai ytaria /	•	rtificate of			g. No. 20	04 07692
	Physici /Medic		1. Decedent's Name (First, Middle, L Fannie	0.		nsic			2. Date of Deat Month 02/20/2	004 Y	3. Time of Death 4:20 A M
	Examir		4a. Facility Name (If not institution, g				7	r Location of Death		4c. County of	
			Charlotte Hall 5. Social Security Number 6.		ome ge (In yrs. last	birthday)	Charlot If Under 1 Year		8. Date of Birth	St. Ma	Birtholace (State or Foreign
	Funeral Director		236-16-8415	1□M 2021F	83	Yrs.	Months Days	Hours Min.	12/01/1	Year)	Country) est Virginia
	yland		Usuaf Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	ecation				10d. Inside City Limits
	8a-1 st	ector	Maryland St. Ma	ry's	Char	lott	e Hall				1 □ YesX X⊠ No
	3a or 2	I Dir	10e. Street and Number 29449 Charlotte	Hall Road			10f. Zip Code	20622	1	0g. Citizen of Wh USA	at Country?
036	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-1 show the Modral Examiner cast be notilized at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces	t Ever in U.S.	-	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2∑ No	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)		American Indian, White, etc. White
2-0	72 ho	eted	15. Decedent's (Specify only highest of	Education grade completed)	16	Sa. Dece	dent's Usual Occup	pation during most of work	king	16b. Kind of Busin	ness/Industry
21215-0036	itled within Hygiene. other than	Completed	Elementary/Secondary (0-12)	5 Coffege (1-4or	5+)	Regi	stered N	during most of work d) UTSE		Medical	_
Maryland 2	permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than enty righty or other traumatic event, Ita M. QRCE.	To Be C	17. Father's Name (First, Middle, La Frank Olivito	St)					e (First, Middle, M ina Laca		
	and 2 sho salth and A n 27 is ma er trauma	•	19a. Informant's Name/Relationship Margaret J. Kens		r 1	4714	Nationa	and Number or Rui 1 Drive C			
Baltimore,	Peges 1 nent of He ant: If iten ary or oth		20a. Method of Disposition 2 Surial 2 Cremation 3 4 Donation 5 Other (Spec			eter	sition (Name of matory or other place ans Cem.	3/1/	04		am, Maryland
Balt	permit. Departr Imports eny inje		21. Signature of Funeral Service Lic	alas -		22	2. Name and Addre	sset Facility Facility Facility Facility Facility	o. Kalas Oxon Hi	Funeral	Home P.A.
	Physician /Medical Examiner	Examiner	23a Pan. Enter the disease, a co- shick, or heart faifure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. TNS Due to (or as	ed the death. Deline. Successful to the death. Deline. Sa consequence of the death. Deline.	o not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	abetes	Approximate Interval Between Onset and Death
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O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the tuneral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		e of pregnancy 2 Fetal dea at time of death		Ectopic pregnancy Other (specify)	,		23d. Date of Month	•
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<u>></u>	Physic this ce al dire	2	1 ☐ Yes 2 № No	Hospital:		-		4 K Nursing Ho	ome 5 Reside		
O D O	th. TAfter tunera	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	ay Year)	n. Time of Infury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division of	Il or Attend after death I Director: / d in by the f	Certification:	3 Suicide 6 Could not determine	be 28e. Pface of In	njury - At home, etc. (Specify)	farm, str	eet, factory, office		28f. Location (Sti City or Town		or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier Certifying I (Check only one) 2 Medicel Ex	Physician: To the best aminer: On the basis of and manner st	of examination	ge, death and/or in	n occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	and due to the ca	use(s) and mann ite and place, and	er as stated. If due to the cause(s)
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_	(3)		30. Name and address of person wh	to completed cause of	death (Item 23a	a) (Type,	Print)	ncetre	diácl.	117	72/70
	Sta	te	31. Date filed (Month, Day, Year)	2. Regist	Signature	230	O'S PVII	ICE IVE	IVICK	1 MUD	CO 18
	Registr		EED 9 / 200	14 Ken	K	Mars	47 J				

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 2004 2:00 pM Clara Susan Leonardi /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Westminster 1122 Singer Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, NOV 17 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1914 1 □ M 2 1 1 F PA Nov 89 Director 183-12-8943 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Westminster 1 Yes 2 No Carroll MD by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 USA 1122 Singer Drive death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3℃ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 is marked other
eny injury or other traumer. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nora Ellen Miller William W. Lutz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Westminster, MD William Thurston/son 1122 Singer Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2/25/2004 Carroll Cremation, Inc Hampstead, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee ²Pritts Affuine Fair Home and Chapel, P.A. K 412 Washington Road Westminster, MD 21157 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to for as a consequence off Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 5 Other (specify) 1 Yes 2 No the 9 Unknown 9 Unknown signed by 23e. Did tobacco use coptribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, pe 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 24 hours after death • Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 | Homicide pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check or one) and manner stated. within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature d title of certifie uw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) militar Puis ració 31. Date filed (Month, Day, Year) State 5 2004 2 FEB Registrar

					State	of Maryl	and / Dep	ertificate	of Deal	tn and i ath	Mental Hy	giene Reg. No. 20	04	07694
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	28a-f	ect	10e. Street and Num					10f. Zip Coo	do			10g. Citizen of	What Count	
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ה ה	72 hc	Be Completed by	(Speci	15. Decedent's E	Education rade completed	")	16a. Dec	edent's Usual Or e kind of work de DO NOT use re	ccupation one during	most of wo	rking	16b. Kind of E	Business/Ind	ustry
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<u></u>	2 should and Men is marke	F	19a. Informant's Na	me/Relationship	(Type, Print)		19b. Ma	ling Address (St	reet and No	umber or Ri	ural Route Numb	er, City or Town	, State, Zip	Code)
Mar	alth a 27 is or train		Robert Le(Compte -	Son		576	4 Hanno	ver C	ourt,	Frederi	ck, Mar	yland	21703
ore,	of He		20a. Method of Disp	osition Cremation 3 l	Dom ovel from	20	b. Place of Dis	oosition (Name o	of place)		Date	20c. Location	- City or Tov	vn, State
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г 5	at the d by the etach	Phy	Ank.	6287	7116	Cun.	01090	6000	4724	5	1 🗆	Yes 2⊠No	3 🗆 Prob	ably 4□Unknown
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5	hysici nis ce I direc	2	examiner? 1 ☐ Yes 2 ☐	No	Hospital:	Inpatient 2	P☐ ER/Outpati	ent 3 DOA	Other: 4	☐ Nursing H	lome 5□Resi)
DIVISION	To the Hospital or Attending Physician: The law within 24 bours after death. Within 24 bours after death. Completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	Certification:	27. Manner of Death 1 □ Natural 2 □ Accident 3 □ Suicide	5 ☐ Pending investigation	on e	nth, Day Year		М	Injury at Work? 1 ☐ Yes	2 □ No		how injury occu		Davis Number
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	To th withir To th comp	Me	29b. Signature and t	itle of certifier	1/1				ense numb		9	29d. Date signe		
)		-	30. Name and addre	se of parear int	completed as:	se of doot /	Itom 22a\ /Tv-			- 1		1-1	12-	
	V		Ronald E					rive, Mt	t. Ai	ry, Ma	aryland	21771		
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

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				Ronald E. Mil	ler M.D.	#4 Culwell	Drive, N	Mount Air	y, Maryla	nd 21771	
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	1. Decedent's Name (First, Mide					2. Date of Death			3. Time of Death
Physician /Medical	Brian D. Lora	nce				Februar	y 18,	2004	0314 A M
Examiner	4a. Facility Name (If not institution	on, give street and nu	umber)	4b. City, Town, or	Location of Death		4c. County	of Death	
	Interstate 695	@ Northbour	nd ramp 795	Baltimo			Bal	timor	:e
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear)	9. Birthpl Count	ece (State or Foreign try)

Funeral | Director

r 28a-f show

ral', or Items 23a or Exactiver count be

"natural"

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 Is marked other any injury or other traumatic event, 90ce.

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

detached

been sig

After

after death death.

within 24 hours a To the Funeral I

filled in by the

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examine

Physician/Medical

9

Completed

Be

۴

Certification:

Medical

Funeral

Completed

Be

death 1

within 72 hours after

Baltimore, Maryland 21215-0036

Usual Residence of Decedent 10a. State 10b. County MD Directo

212-15-9831

Anne Arundel

10c. City, Town or Location Annapolis

31

Yrs

1972 12,

Country) Massachusetts

> 10d. Inside City Limits 1 ☐ Yes 2 TNo

10e. Street and Number 1150 Southview Drive

12. Was Decedent Ever in U.S. Armed Forces?

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

21401

 Race - American Indian, Black, White, etc. Specify: White

11. Marital Status 1 Never Married 2 Married þ 3 Widowed 4 Divorced

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)

1**∑** M 2□ F

1 ☐ Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

10f. Zip Code

16b. Kind of Business/Industry

10g. Citizen of What Country?

USA

Elementary/Secondary (0-12)

College (1-4or 5+) 12

Manager 18. Mother's Name (First, Middle, Maiden Sumame)

Restaurant

17. Father's Name (First, Middle, Last)

Larry D. Lorance

Vera G. Harnden

2004

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 756 Ocean Parkway

Berlin, MD 21811

Vera G. Morrow/Mother

20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Stevensville Cemetery

Date 21 February Stevensville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

110mol(1) n

22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 Approximate Interval Between Onset and Death

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ead turles Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea

2 Fetal death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Day

9 Unknown

4☐Pregnant at time of death 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Year

24a. Was an autopsy performed? 1X Yes 2 □ No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No

25. Was case referred to medical examiner? 1X Yes 2 □ No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

Street

Other: 28c. Injury at Work? 1

28d. Describe how injury occurred

At scene 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) accident

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Thomicide

5 Pending investigation 6 ☐ Could not be determined

2:58 M 2/18/04 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 📉 No

Driver of a car involved in single car 28f. Location (Street and Number or Rural Route Number, City or Town, State) sterstate 695 at NB ramp 795

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Dey, Year) February 18, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZABILICALA 31. Date filed (Month, Day, Year)

32. Regisfar's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar



ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 07697 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 03:08 AM Lalor William 02 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9. Birthplece (State or Foreig Country) Washington DC 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplece (State or Foreign Funeral Days Hours 15 M 2 ☐ F 55 219-48-9807 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show r than "naturel", or Items 23a or 28a-f shov the Medical Examinar must be notified at ty⊠Yes 2 No Maryland Anne Arundel Annapolis Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 217-G Victor Parkway 21403 U.S.A. death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after I ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ Xio Specify. White Specify: þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than Police Officer Dept. of Defense 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Jerome Lalor Ethel Mae Mackey 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Nichols/daughter 1412 Mariner Drive Arnold, MD 21012 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: If ite
eny injury or of St. Mary's Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/25/2004 Annapolis, MD 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Renal cancer 5 mas resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, I aming to miniculate cause. Enter Underlying Cause (Disease or injury Dire to for its a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialphysician Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 ☐ Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 3□ DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059173 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Rd, Swite 300, ANNapolis, Kemmer, 31. Date filed (Month, Day, Year) 32. Re strar's Signature FEB 2 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar 07698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20, 2004 **Physician** February Robert Donald Lovering 5:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
April 10, 1932 Massachusetts 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 M 2 □ F Vrs 71 017-24-2958 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Itams 23a or 28a-f ehow the Medical Examinar must be rigitified at 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2941 Broad Court 21401 U.S.A. Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1950–72 1 ☐ Never Married 2 ☑ Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced "natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Chief Warrant Officer U.S. Army 12 and Mental Hygie 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Warren J. Lovering Marquerite J. Alley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If itam 27 le
any injury or other trau Auriol Lovering/wife 2941 Broad Court Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State Maryland Veterans Cem. 2/24/2004 Crownsville, MD 4 Donation Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Se 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** hour /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 Yes 2 No 3 Probably 4- Inknown Be Completed peen Obesity 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? certificate Arrythmia 1 Yes 2,₹2,₹\0 or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient &ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 0031998 Feb. 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michele Smadja-Gordon, MD 116 Defensé Highway, Suite 400 Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. R strar's Signature State Registrar FEB 23 2004

		1- State Ragistrar	State of Ma	ryland / Dep		lealth and	Mental Hygi	•	07700
Physic /Medi Exami	cal	Decedent's Name (First, Middle, I Margaret Eliza Aa. Facility Name (If not institution, g	beth Latha	m	4b. City, Town, o	or Location of Deat	2. Date of Death Month February		3. Time of Death 10:00 AM
Funeral Director	Service (213-44-6853		(In yrs. last birthday	Heler If Under 1 Year Months Days		8. Date of Birth (Month, Day, February 1	St. Mary 9. Birth Cot 8, 1919Mary	
he Maryland 8a-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland St. Ma		10c. City, Town or I Helen					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
death with to	Funeral Director	10e. Street and Number 30051 Point Look. 11. Marital Status	out Road 12. Was Decedent Endamed Forces?	ver in U.S. 13	10f. Zip Code 206 Was Decedent of If Yes, specify Cub			USA 14. Race - Amer Black, White	ican Indian,
2 hours after aturel; or its	þ	1 Never Married 2 Married 3 M Widowed 4 Divorced 15. Decedent's	1 Tyes 2 No. If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Speciful.	hite
and ZIZIS-UUSO be filed within 72 hours after death with the Maryland hat Hyglene. d other than "naturel", or Items 23a or 28a-f show event, the Medical Examinat must be notified at	e Completed	(Specify only highest of Elementary/Secondary (0-12) 12	College (1-4or 5+)	edent's Usual Occup e kind of work done DO NOT use retire Homemaker		ne (First, Middle, M	Own Home	
aryica should nd Men n marke umatic	To Be	Joseph R. Downs 19a. Informant's Name/Relationship	(Type, Print)	1		and Number or Ru		City or Town, State, Zi	p Code)
DallIINOTC, INE permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other trai		Leonard J. Lathan 20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State	20b. Place of Disp cemetery, cri		сө) 2/10	shington, Date 2 0/2004	Oc. Location - City or T Helen, Man	
permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service Lic 21. Signature of Funeral Service Lic License License Li	Gardiner	P	.O. Box 270	Leonardtow	neral Home, n, Maryland	20650	Approximate
Physician /Medical Examiner		shock; or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	. Sen	consequence of):					Interval Between Onset and Death
xecuted and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):					
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cai	IF FEMALE:	d. Co!	77					
at the death cer	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3 me of death 5	□Ectopic pregnanc □ Other (specify) _			23d. Date of deliv Month	Day Year
w requires the speed signed is should be de	Completed by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause gn	ven in Part I.		acco use contribute to to a 2 No 3 Proj	bably 4 AU nknown
VICAL DE icien: The la sertificate has ector, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Lou		autopsy perform 1 Yes 2	ed? death?	
Attending Phys r death. ector: Atter this eby the funeral dir	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day	t 2 🗆 ER/Outpatie 28b. Time Yea <i>r)</i> Injury	of 28c. Injur	y at	lome 5 Aesiden 28d. Describe how	nce 6 Other (Speci v injury occurred	(y)
Spital or Att hours after de merel Direct	al Certification:	3 Suicide 6 Could not determine 4 Homicide 129a. Certifier 12 Certifying 1	building, etc.	my knowledge, dea	ath occurred at the ti	me, date and place	City or Town,	use(s) and manner as s	stated.
To the Ho within 24 P To the Fu completely	Medical	(Check only 2 ☐ Medical Ex 29b. Signature and title of certifier	aminer: On the basis of e	xamination and/or i	29c. Licens	opinion, death occu	rred at the time, dat	de and place, and due to de	o the cause(s)
700		30. Name and address of person with Manjo Panwala,			•	fornia, N	-/	- 4	
St Regist	ate rar	31. Date filed (Month, Day, Year)	32 Parietrar		^				

		T = For State Registrar	State of N	Maryland	d / Depa <i>Cei</i>	artment o	of Health of Deat	and I	Mental Hy	giene Reg. No. 2	004	07701
Physici	an	1. Decedent's Name (First, Middle,							2. Date of De Month	Day	Year	3. Time of Death
/Medic		Hildegard							Februa	-	.004	8:20 AM
Examin	ıer	4a. Facility Name (If not institution, St. Mary s Nur	_				own, or Location		h		Mozer	l a
Funeval				Age (In yrs. la	ast birthday)	If Under 1	Year If Unc	ler 24 Hrs.		rth	Mary 9. Birthp	lace (State or Foreign
Funeral Director		267-05-0939	1□M 2⊠F	8	39 Yrs.	Months D	Days Hour	s Min.	May 28	1914	Germa	itry)
pu ,		Usual Residence of Decedent 10a. State 10b. County		100 City	, Town or Lo	onting					1	0d. Inside City Limits
shov	ō	Maryland St. Ma	ev!c		nardto						'	1 ☐ Yes 2 📉 No
28a-1	rect	10e. Street and Number	- I y 3	Leoi	laruco	10f. Zip Co	ode			10g. Citizen o	of What Cour	ntry?
3e or	I D	42095 White Poin	nt Beach R	oad			20650			US	A	
ems 2	Funeral Director	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S	S. 13.	Was Deceden	nt of Hispanic	Origin? (S	pecify Yes or No to Rican, etc.)	o- 14. R	lace - Americ	
or He	by Fu	1 Never Married 2 Marrie	ld 1 ☐ Yes 2 [No		1 ☐ Yes 2 ፟			,	Spe		nite
hour:	q pa	3 X Widowed 4 □ Divorced 15. Decedent's	Year or Date	s:	16a Dece	dent's Usual (Occupation			16b Kind of	Business/Inc	dustry
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d with giene ar tha	Completed	Elementary/Secondary (0-12)	College (1-4d	Ji 5+)	I	lomemal	ker			Ow	n Home	<u>. </u>
al Hy al oth	Be (17. Father's Name (First, Middle, La	ast)						ne (First, Middle	, Maiden Sum	ame)	
ould to	ဥ	Paul Eric Zell							Mueller			
12 sh h and 7 Is m traum		19a. Informant's Name/Relationshi David Eugene W.							urai Route Numb			Code) 1, MD 20650
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumette event, the Medical Exam and Le Indiffical at Once.		20a. Method of Disposition	Hoce, Boll	20b. Pf	ace of Dispo	sition (Name	of)	Date		n - City or To	
ages ant of at: If if		1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ILE		natory`or othe norial G		2/11,	/2004	Waldorf,	Maryla	ind
mit. F partme portar r injur		21. Signature of Euneral Service Iti			M22	Name and	Address of Fa	cility Fur	neral Home			
Departing Department of the particular perturbation of the par		The chael Xe	ru Harde	ner)					m, MD 206			
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aath certifi attending for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ❷ No 9 ☐ Unknown		1 2 ☐ Fetal t at time of de	death 3	Ectopic preg Other (speci			1		Date of delive Month	ery Day Year
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sw rec	Completed		1281	neus	ha >	~ £		,	24a. Was		. Were auto	psy findings available
The la	E O		SAP	Vane	Malla	OTh	ront	7/2	auto perfe 1 □ Yes	ormed?	death?	mpletion of cause of 2□ No
rsician: The law s certificate has E lirector, page 2 s	BeC	25. Was case referred to medical examiner?	<i></i>	-010		L1.V	1	ace of Dea	ath (Check only			
hysic this ce al dire	ဥ	1 ☐ Yes 2 No	Hospital:		ER/Outpatier			Nursing H	lome 5 🗆 Res			0
anding P sath. or: After (Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	ation	njury Day Year)	28b. Time of Injury	28c	: Injury at Work? 1 □ Yes 2	□No	28d. Describe			
ital or Att rs after d al Diract	Certific	3 Suicide 6 Could no 4 Homicide determin	and 286. Place of	Injury · At hor , etc. (Specify	me, farm, str	eet, factory, o	office		28f. Location (City or To		nber or Rura	l Route Number,
To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certifica	ledical	(Check only 2 Madicel E	Physician: To the be xeminer: On the basis and manner	s of examinati		vestigation, in	my opinion, o	leath occu		date and plac	e, and due to	the cause(s)
With Con	Σ	29b. Signature and title of centrier	Ala	Wos	-MI	29c. L	License number	96L	419	29d. Date sign	ned (Month, I	Day, Year)
IM		[/ _		4035 T	hree l	6	Road Ho	ollyw	ood, MD	20636		1
Sta Registr		31. Date filed (Month, Day, Year)	1 2004 Reg	rar's Signat	ure	Smalle						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For	State o	f Marylan	d / Depa	artment of H	lealth ar	nd Me	ntal Hygi	ene		
		1	State Registrar			Cei	tificate of l	Death		Reg	3. No. 2 (104	07702
			1. Decedent's Name (First, Middle, Last)						2	. Date of Death Month	Day	Year	3. Time of Death
	sician edical	_	Kenneth	Ric	chard	Lo	ngenett			Februar	-		8:09 p M
Exa	miner	ľ	4a. Facility Name (If not institution, give st		_		4b. City, Town, or				4c. County		
x			Calvert Memorial Ho 5. Social Security Number 6. Sex	spita	7. Age (In yrs.	last birthday)	Prince If Under 1 Year	If Under 24		Date of Birth		9. Birth	place (State or Foreign
Fune Direc				M 2□F	70	Yrs.	Months Days	Hours	Min.	Month, Day,	1933	Cou	Virginia
		-	Usual Residence of Decedent		100 0	ty, Town or Lo	eation						10d. Inside City Limits
arylan			10a. State 10b. County MD Prince Geo	argo!		•	oper Marl	boro					1 ☐ Yes 2X No
the M 28a-f	Director	-	MD Prince Geo	Jige .	3	<u></u>	10f. Zip Code	2020		10	g. Citizen of	What Cou	ntry?
3a or	Ċ		7915 Trumps Hill R	oad				2077	2		U	SA	
death ms 2	Funeral	-			edent Ever in U	l.S. 13.	Was Decedent of H	ispanic Origin	n? (Speci	fy Yes or No-		e - Ameri ck, White,	can Indian,
ours after death with the Maryla	L.		1 Never Married 2 Married	1 X Yes If Yes, Gi	2 □ No ive	l.	1 ☐ Yes 2 💢 No	Specify:		,	Specif	v.	
72 hours after death with the Maryland natural; or Items 23a or 28a-f ehow	by by		3 ☐ Widowed 4 ☑ Divorced		Dates: 1953	16a Dece	dent's Usual Occup	ation		1	6b. Kind of B		vhite Idustry
in 72 n na	plot		(Specify only highest grade Elementary/Secondary (0-12)			(Give	kind of work done of DO NOT use retired	during most o d)	of working				
filed within Hygiene.	Completed	5	11	College	1-401 547	owne	r, operat						ce station
d oth	Be G		17. Father's Name (First, Middle, Last)					_		First, Middle, M	aiden Sumar		-01 oud
should be nd Mental			Richard Clayton		ngenett		ng Address (Street	Laura		Pouto Number	City or Tourn		cCloud
d 2 sh th and 17 is n	traun		19a. Informant's Name/Relationship (Type Kenneth L. Longene		son		15 Trumps						
Heal Heal	omer	-	20a. Method of Disposition	•	20b. F	Place of Dispo	osition (Name of matory or other place		Da		0c. Location		
Pages ent of nt: If i	יץ פר		1 X Burial 2 □ Cremation 3 X Re 1 Donation 5 □ Other (Specify)	moval from	State		lls Mem.		2-2	6-04	Quiet	Dell,	WV
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natur	any inju	-	21. Signature of Funeral Service License	, 01		2:	2. Name and Addre	ss of Facility					
1 85E	a 8		William K	1X	000		ausch Fun					s, M	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that a cause on	caused the deal	th. Do not en	ter the mode of dyin	ng, such as ca	ardiac or	respiratory arre:	st,		Approximate Interval Between Onset and Death
Physic		1	Immediate Cause (Final disease or condition resulting in death)	(ardi	90	Arrhy	thmi	9				10 minutes
/Medi Exami			1	Due to	(or as a consec		ic Caro	lin V	ner	21/200	disea	00	more than 2 Yeare
		<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec		10 cenc	40 V	CESC	ula .	17.6	-2.0	a / ca- a
cuted	ial-transit		Cause (Disease or injury that initiated events c.										
be executed sician and	urial-i	Y	resulting in death) Last	Due to	(or as a consec	quence of):							
cate be exphysician	g 5	ביי	d.										
ath certifi	ISB as	nwe.	IF FEMALE: 23b. Was decedent pregnant 23		utcome of pregn						23d. Da	te of deliv	ery
The law requires that the death certificate ale has been signed by the attending phys	d for t	2	in the past 12 months?	4☐Preg	birth 2 ☐ Feta nant at time of c		□Ectopic pregnancy □ Other (specify) _	y 			Me	onth	Day Year
by th	etache	2	9 Unknown	9□ Unkr						Dia autor			
w requires that the speen signed by the	8 4	à	Part II. Other significant conditions con	_			. 0	10.00	r.			tribute to i	the cause of death?
law requires as been signe	plnod	מנים	Hortic Steno				1 Regun	91(41)	<u>C</u> n				opsy findings available
e law	9625	Completed	Cerebro Vascu	007	HCCIC	<i>lent</i>				24a. Was an autopsy perform	ed2	prior to co death?	ompletion of cause of
VII.di ician: Th certificate	or, pa	ב ב	25. Was case referred to medical					26 Place o	of Death	1 Yes 2		1 🗌 Yes	2 ∐ No
ysicia	direct	2	examiner?	ospital:	Inpatient 2] ER/Outpatie	nt 3□ DOA Ott	ner		e 5 Resider		ner (Speci	(fy)
ng Phy fler this	neral		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o	Wo			3d. Describe how	w injury occur	rred	
VISION Attanding or death. ractor: Afte	the fu	Sa E	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ N		of Landing (Con		bar or Du	Paula Musika
UNISION OF VITAL INC. To the Hospital or Attanding Physicien: The law within 24 hours after death. To the Funaral Diractor: After this certificate has	in by	Ceruncation:	4 Homicide determined	28e. Plac build	e of Injury - At high ding, etc. (Speci	nome, farm, st ify)	reet, factory, office		28	City or Town,	State)	DBr Or Mur	al Route Number,
spital	B €		29a. Certifier 1 Certifying Phys	ician: To th	ne best of my kn	owledge, dea	th occurred at the ti	me, date and	place, ar	nd due to the ca	use(s) and m	anner as	stated.
e Hos	letely	edical	(Check only 2 Medical Examinone)		basis of examin nner stated.	ation and/or in	nvestigation, in my	opinion, death	n occurred	d at the time, da	te and place,	and due	to the cause(s)
To th To th	comp	Σ	29b. Signature and title of certifier	_	(29c. Licens		/		d. Date signe	•	
		14	regu	_ (_	Smo	eng		506				- 2:	3-04
2			30. Name and address of person who con 5851- Deale			m 23a) (Type	Print) GY	AN.	C.	SURI	AWA)	
	State		31. Date filed (Month, Day, Year)		W7W+	nature /	Soul I	reale	/	110 2	0151		
Re	siai gistra	-	FEB 2 3			as St.	Coule	P					

State of Maryland / Department of Health and Mental Hygiene 2004 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 20, 2004 **Physician** 3:06p M Victor Garnett Lucas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles 11915 Homestead Place Waldorf If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | Min. | March 3,1939 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Fľorida 579-72-4733 64 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or iteme 23a or 28e-f ehow ent injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Waldorf Directo Maryland Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20601 U.S.A. 11915 Homestead Place Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned 1 ☐ Yes 2 XNo Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Transportation Bus Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maggie Unknown Elbert Gary 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11915 Homestead Place, Waldorf, Md. 20601 Shirel B. Lucas 20b. Place of Disposition (Name of commeter), crematory or other place) February 24,2004

Metropolitan Funeral Service 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640 21. Signature of Funeral Service Licenses M00668 23a. Part1. Enter the dease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition FLER **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death Day Year in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 Stunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 00 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2₽No Certification: To 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Injury 1 AMatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospitel 1 📂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 0 31. Date filed (Month, Day, Year) 32. Resstrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

FEB 24

2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		ı	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment e <i>rtificate</i>			nd Mei		\sim) 4	07704
	Physicia		1. Decedent's Name (First, Middle, La NETTIE PEARL	ast) LEGGETT						Date of Death BRUARY	Day 22, 2	66 4	3. Time of Death 0620 M
	/Medic Examin		4a. Facility Name (If not institution, gi 20816 NETZ ROAD			4b. City, To		ocation of ONSB(ORO		4c. County o	Death WASE	HINGTON
	Funeral Director			Sex 7. Ag 1 ☐ M 2 1 F	e (In yrs. last birthda 75 Yrs.	Months		If Under 2 Hours	Min. J	Date of Birth (Month, Day, Y LY 26,	1928	9. Birthp Coun M	lace (State or Foreign IARYLAND
	ow other		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						11	Od. Inside City Limits
	the Marylan 28a-f show notified at	Director	MARYLAND WA	SHINGTON		10f. Zip 0		OONSI	BORO	100	1. Citizen of Wi	nat Coun	1 ☐ Yes 2 No
	th with t 23a or 2	al Dir	20816 NETZ ROAD					217			, O		S.A.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show importent: If item 27 is marked other than "netural", or items 23a or 28a-f show appring yor other traumatic event. The Medical Examinative traumatic and once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.S. 13 No	Nas Decede If Yes, specif		nanic Orig Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- an, etc.)		Americ White, WHI	
21215-0036	n 72 ho "netur edical	leted	15. Decedent's E (Specify only highest g	rade completed)	(Giv	edent's Usual ve kind of work DO NOT use	done dui	on ring most	of working	16	b. Kind of Bus	iness/Ind	Justry
212	ed within ygiene. ser than t. the M	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		MEMA				WO .		OME
land	id be fillental Hyked oth	To Be	17. Father's Name (First, Middle, Las JOSEPH BERNARD				1			irst, Middle, Ma ATHERIN			
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Me		19a. Informant's Name/Relationship WILLIS E. LEGGE			3				ORO, MA	•	tate, Zip 217	
	ss 1 and of Health item 27 r other to		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3		20b. Place of Dis		of	1	Date		c. Location - C	ity or To	wn, State
Baltimore,	nit. Pagartment prtent: Injury of the		'4 □ Donation 5 □ Other (Spec	ify)	BOONSBO	RO CEME			/25/20	004 B 7606 OL			MARYLAND
Ba	permit. Departr Importe any inji		KELLY A. ZIA	merhali —		BAST F	-		OME	BOONSBO	RO, MAL		ND 21713
	Physician		23a. Part1. Energia sease, or conshock, or heart failure. List onlingmediate Cause (Final	mplications that cause y one cause on each li	d the death. Do not e	inter the mode		such as o		espiratory arres	t,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequence of):	V Br	Con	100					Lycaro
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated exertises)	b. — Due to (or as	a consequence of):								
Ć,	certificate be executed ding physician and ise as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):		-						
8760,	cate be physicia the bur	dicai	•	d								4	
P.O. Box 6		by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetel death	B □Ectopic prediction of the state of the s					23d. Date Mont		ery Day Year
	·= 0 T	ed by Pr	Part II. Other significant conditions	contributing to death t	out not resulting in the	underlying ca	use given	in Part I.					ne cause of death?
Division of Vital Records,	The law ate has b page 2 st	Completed								24a. Was an autopsy performe	pr de	ere autop or to cor ath?] Yes	psy findings available inpletion of cause of 2 No
Vita	Physicien: The this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpat	ent 3 🗆 DOA	Other			Check only one) 5 🕅 Residen		(Specify	()
on of	fer fer	tion; T	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Inju (Month, Da			c. Injury a Work?	at	280	d. Describe how			,
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine		jury - At home, farm, tc. (Specify)			_	_	Location (Stre City or Town,	et and Number State)	or Aura	l Route Number,
	Hospita 24 hours Funere	edical C		Physician: To the best aminer: On the basis of and manner st	of examination and/or								
	To the within To the comple	Me	29b. Signature and title of certifier	4 0	4	29c.	License r				f. Date signed		
	4		30. Name and address of person wh	completed cause of	death (Item 23a) (Tun	e, Print)		1160			2. S	-3.	04
5	X-LP		Michael V.	McCorn	rar's Signature	10 M	edic	1	Cump	100	Dejen	hu	mo.
	Sta Regist		31. Date filed (Month, Pap Year)3	2004	rar's Signature	Joanne							

1- For State C		artment of He <i>rtificate of D</i>			ene 2 (g. No.	004 07705
1. Decedent's Name (First, Middle, Last) Physician CHAU KIU LAI				2. Date of Death Month FEBRUARY	Day	3. Time of Death
/Medical 4a. Fecility Name (If not institution, give street and nu LAUREL REGIONAL HOSPITA)		4b. City, Town, or L	ocation of Death	<u> </u>	4c. County	y of Death CE GEORGE'S
Funeral 5. Social Security Number 6. Sex 1 M 2 4 F	7. Age (In yrs. last birthday, 81 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JAN. 23,		Birthplace (State or Foreign Country) CHINA
Usual Residence of Decedent	10c. City, Town or L	ocation				10d. Inside City Limits
MARYLAND MONTGOMERY 10e. Street and Number	BURTONSVI	-		10	- Citizen of	1 A Yes 2 □ No What Country?
10e. Street and Number 14318 DUVALL HILL COURT		10f. Zip Code 20866			CHINA	What Country?
11. Marital Status 12. Was Dec Armed F	2 X No	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 🕅 No	panic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Bla	tce - American Indian, ack, White, etc. ify: ASIAN
15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupation is kind of work done du DO NOT use retired)	ion uring most of work	king 1	6b. Kind of E	Business/Industry
The state of the s	1-4or 5+)	MAKER			WN HOM	ME
E SEDE OF CITETION TAT			BO WAN I			
SING CHEUR LAT 19a. Informant's Name/Relationship (Type, Print) EMILY LI FUNG — DAUGHTER 20a. Method of Disposition 1. Burial 2 Cremation 3 Removal from 1. Burial 2 Cremation 3 Removal from 1. Burial 2 Cremation 3 Removal from 21. Signature of Funeral Service Licensee		ing Address (Street and				
EMILY LI FUNG- DAUGHTER 20a. Method of Disposition	20b. Place of Disp	osition (Name of ematory or other place)		The state of the s		- City or Town, State
20a. Method of Disposition 1 Dispos	WASHINGT	ON NAT'L C	EM.2/17		UITLAN	
21. Signature of Funeral Service Licensee		22. Name and Address 1800 NEW H				
23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	caused the death. Do not er each line. CEREBRAL A			or respiratory arre	st,	Approximate Interval Between Onset and Death 20+ YEARS
resulting in death)	(or as a consequence of):					
Sequentially list conditions, if any, leading to immediate number of the property of the prope	(or as a consequence of):					
ff any, leading to immediate constitution of the property of t	(or as a consequence of):					
	to a standard					1
23b. Was decedent pregnant	nant at time of death 5	□Ectopic pregnancy □ Other (specify)				ate of delivery Month Day Year
Part II. Other significant conditions contributing to	_	underlying cause giver	n in Part I.		**	ntribute to the cause of death? 3 Probably 4 Unknown
CORONARY ARTERY DISEASE PERIPHERAL VASCULAR DIS	EASE			24a. Was ar autopsy perform 1 Yes 2	red?	b. Were autopsy findings available prior to completion of cause of death? 1 \(\subseteq \text{Yes} = 2 \subseteq \text{No} \)
A Second Control of the Control of t				th (Check only one)	
Z 4 4 = -	Inpatient 2X ER/Outpatie	of 28c. Injury		ome 5 Reside 28d. Describe ho		
To be the control of	nth, Day Year) Injury se of Injury - At home, farm, s ding, etc. (Specify)	M 1□Y	es 2 □ No	28f. Location (Str City or Town		nber or Rural Route Number,
29a. Certifier 1 A Certifying Physician: To the Control of the Con	ne best of my knowledge, dea basis of examination and/or inner stated.	ath occurred at the time investigation, in my opi	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and nate and place	manner as stated. e, and due to the cause(s)
ending 29b. Signature and alle M certifier	L MD	29c. License D27865			2/14/2	ned (Month, Day, Year) 004
30. Name and address of person who completed car MARK K LI, M.D. 1721 UN			ON MD 2	0902		
MARK K LI, M.D. 1/21 UN						

	•	For State Registrar	State of Marylan		artment of Health an		giene 2004	07706
Physici		1. Decedent's Name (First, Middle, Last)				2. Date of De. Month	Dey Yeer	3. Time of Death
/Medic	al	ELEANOR G. LAVINE 4a. Fecility Name (If not institution, give st	troot and number)		4b. City, Town, or Location of D	FE 5	4c. County of Deet	
Examin	er	HEBREW HOME OF GREA		ON	ROCKVILLE		MONTGOMER	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	ast birthday)	If Under 1 Year If Under 24	Min. (Month, De	h 9. Birt	nplace (State or Foreign untry)
Director		183-14-4380	M 2XIF 8	2 Yrs.		NOV. 1	5, 1921 PEN	NSÝLVANIA
land Dw	 	Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or L	ocation			10d. Inside City Limits
Mary Find	ţ	MARYLAND MONTGOMERY	y OLNE	Y				1 X Yes 2 No
death with the Maryland ma 23a or 28e-f ahow	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Co	untry?
ath w		4120 ALFALFA TERRA		C 12	20832 Was Decedent of Hispanic Origin		U.S.A.	rican Indian
ter de Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	 Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No 	3. 13.	If Yes, specify Cuban, Mexican, F	uerto Rican, etc.)	Black, White	
ral', or	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2X No Specify:		Specify: WH	ITE
72 hc	ompleted	15. Decedent's Educ (Specify only highest grade	eation completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during most o DO NOT use retired)	f working	16b. Kind of Business/	Industry
within ene. than than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMA			OWN HOME	
Hygi other	O	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle,	Maiden Surname)	
Venta Venta Prked price	ToB	HARRY	GROSSINGER		BEATRI		GRASS	
2 sho and l is ma		19a. Informant's Name/Relationship (Typ			ing Address (Street and Number of			
1 and Health em 27 ther t		ROBERT J. LAVINE/ 20a. Method of Disposition	SON 20b. F	lace of Disp	SNOWSHOE LANE osition (Name of	Date Date	20c. Location - City or	
y or of		1 X Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		EL CONG. CEM.	2/12/2004	WASHINGTON	, D.C.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28e-f show monthly injury or other traumatic event, the Madical Examination is unit be notified at ance.		21. Signature of Funeral Service License			2. Name and Address of Facility ANZANSKY —GOLDBE			
P P F P P		Sonald C. X	Hottlemer	- I	LZO ROCKVILLE P.	LKE, RUCKV	ILLE, MD ZU	834
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused to eat se cause on each line	h. Do not er	iter the mode of dying, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a conseq	uence of):	carle pos	andon	dr sens	_
be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq					
be executed ician and burial-transif		resulting in death) Last	Due to (or as a conseq	uence of):				ï II
# × 6	edlcai							
To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Fets 4 ☐ Pregnant at time of conditions of the c	I death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	ivery Day Year
w requires that the state of the signed by should be detact	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the	underlying cause given in Part I.		obacco use contribute to	the cause of death?
w requ	Completed					24a. Was	an 24b. Were as	utopsy findings available
The law sate has page 2:	dwo					auto perfo	rmed? death?	completion of cause of 2 □ No
ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				f Death (Check only		
Physician: this certific al director,	2	1 ☐ Yes 2 ☐ MG		ER/Outpatie			dence 6 Other (Spe	cify)
After funera	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	111	how injury occurred	
death death octor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, s			Street and Number or R	ural Route Number,
s after s afte	Certi	4 Homicide	building, etc. (Speci	(y)		City of 10	wii, Statej	
To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	sician: To the best of my knonar: On the basis of examination and manner stated.	owledge, dea ation and/or	ath occurred at the time, date and nvestigation, in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
To the within To the comp	Σ	29b. Signature and title of certifier	118		29c. License number		29d. Date signed (Mont	
10		Construt	Lonning		0:4490	7	Jeb 11,	2004
		30. Name and address of person who co	ompleted cause of death (Ite	n 23a) (Type	Print) CONSUE (pockent)	o den	Truce, Im	2
Si	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 4	load !	- , ww	land al	- Contract of the Contract of
Regis		LER I 4 50	NA General	fed	spires			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) Vaar Month **Physician** 2:10 P^M FEBRUARY 14, 2004 LESSELROTH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY ROCKVILLE 10500 ROCKVILLE PIKE #1225 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖺 F 98 051-24-7561 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c City Town or Location ral', or items 23a or 28a-f show Exercises must be notified at 1 X Yes 2 ☐ No MARYLAND | MONTGOMERY ROCKVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 10500 ROCKVILLE PIKE #1225 20852 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: WHITE Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 4 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental Hitant: If item 27 is marked oth jury or othar traumatic even Be SARA JOSEPH LEW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11505 WESTHILL DR., ROCKVILLE, MD 20852 NAOMI LEVIN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 □Donation 5 □ Other (Specify) KING DAVID MEM. GDNS. 02/16/2004 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE Physician 1 WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEARS LYMPHOMATOSIS Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed LYMPHOMA resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical d ADVANCED AGE IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Dav Year 5 Other (specify) o 9☐ Unknown 9 Unknown ፩ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, 1 Yes 2 No 3 Probably 4 10 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 🔀 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 ☐ Yes 2 X No Division of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After t or Attending 5 Pending investigation 1 XNatural after death.

Diractor: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number merce FEBRUARY 14, 2004 D06959 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8808 HIDDEN HILL LN., POTOMAC, MD 20854 ELBA MARTINEZ, M.D., 31. Date filed (Moath 32. Registrar's Signature State oaks Registrar

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBRUARY 20 2004 8:35 P M LESLIE ELIZABETH OWEN /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner GAITHERSBURG MONTGOMERY WILSON HEALTH CARE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Dec. 9 1 9. Birthplece (State or Foreign Country)

0 0 10 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🛛 F Months 1915 Dec. 88 298 05 9033 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hydiene. Importent: if item 27 is marked other than "natural; or items 23s or 28s-f show injury or other traumatic event, the Mayoral Examiner must be notified an once. 1 ☐ Yes 2 No Rockville Montgomery Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20853 13409 Justice Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No White 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Luie Malone Charles 0wen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Damascus, Md. 24429 Club View Drive, Stephen O. Leslie / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/24/04 * 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park Olney, Maryland 22. Name and Address of Facility
Muriel H. Barber Funeral Home
P. (). Box 5038, Laytonsville, Md. 21. Signature of Funeral Service Licenses XXo Saul 20882 w. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Massive vascular alleded Luceh **Physician** CES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the o 9 Unknown 9 Unknown signed by ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 2 should be 1 Tyes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed page certificate 1 Tes mene 2 🗷 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospitel 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie dell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LRUBSET BIRSCHBACH, MIL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 25 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 0 0 4 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2:45 P M February 18, 2004 Howard Lessoff /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 11811 Enid Dr. Potomac Montgomery If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 9-23-30 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex 5. Social Security Number **Funeral** Hours Min. 1 反 M 2 □ F 73 Mass. 018-24-5316 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Mousal Example must be notified at 1 ☐ Yes 2 ☑ No Funeral Director MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 11811 Enid Dr. U.S.A. 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Physicist Naval Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alexander Lessoff Frances Palenovsky 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera Lessoff - Spouse 11811 Enid Dr. Potomac, MD 20854 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Menorah Gardens 2-20-04 Rockville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 11800 New Hampshire Ave. 21. Signature of Funeral Service Ligenses Duane Silver Spring, MD 20904 Hines-Rinaldi F.H. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreatic cancer **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Completed by Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 Yes 2x No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? 1 ☐ Yes 2 🔀 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 MResidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After fniury 1 XNatural 5 Pending investigation s after death. 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D44157 Feb. 19, 2004 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Ira Berger, M.D. 12017 Locks Rd., Rockville, MD 20854 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State 23 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 6:04 P_{M} 19, 2004 **Physician** Irma Lindstrom /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Dec. 26, 1 Holy Cross Hospital Montgomery 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2X F Puerto Rico 218-54-8245 1920 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at Rockville Maryland 1 XYes 2 ☐ No Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 303 Adclare Road 20850 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married 1⊈Yes 2□No Specify: Puerto Rican Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importaent: If tiem Z7 is marked oth any injury or other traumatic event pages. Be Enrique Ana Luisa Jimenez Jose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Minning (Daughter) 321 Market St. West, #101, Gaithersburg, Md. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) February 27 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory Beltsville, Md. 1 4 ☐ Donation 5 ☐ Other (Specify) Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, Md. 20910 21. Signature of Funeral Service Licensee Trooper K101261 sund -0 Approximate Interval Between Onset and Death 23a. 4-m1. Inter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or h-lart failure. List only one cause on ach line. Immediate Cause (Final disease or condition resulting in death) Perforated Bowel **Physician** /Medical Due to (or as a consequence of): **Examiner** Fecal Impaction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Box 68760, 23 A death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 XNo 4□Pregnant at time of death 5 Other (specify) detached I Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ be icate has been sig r, page 2 should b Atherosclerotic Cardiovascular Heart Disease 1 Tes 2 No 3 Probably 4 Unknown Completed Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 🗆 No 1 Yes certificate 1 ☐ Yes 2 X No Division of Vital : After this certifical funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Medicai Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 XNatural 5 Pending n 24 hours after death. he Funerel Director: Att pletely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 55522 war February 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Gerard, M.D.; 1500 Forest Glen Rd., Silver Spring, Md. 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks Registrar FEB 27 2004

			For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of H	leaith ar Death	nd Mental Hy	giene	2004	07711		
			Decedent's Name (First, Middle	le, Last)					2. Date of De	eath		3. Time of Death		
	Physicia /Medic		Vera	Linz					Februa	nry 21	Year 2004	11:00 P M		
	Examin		4a. Facility Name (If not institutio	n, give street and n	umber)		4b. City, Town, or	Location of	Death	4c. 0	County of Death			
			Maplewood Park				Bethes		411		ontgomer			
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 □ F		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Di			lace (State or Foreign try)		
	Director		067-24-5077 Usual Residence of Decedent	X	78				9/3/19	25	Czec	hoslovakia		
	yland iow		10a. State 10b. County	,	10c. (City, Town or Lo	cation				1	0d. Inside City Limits		
	Mar.	io	Maryland Mont	gomery		Bethe	sda					1 XYes 2 No		
	or 28	Directo	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cour	itry?		
	23e	ai	9707 Old Georg			13AL	2081				ted Stat			
	tems	Funeral	11. Marital Status	Armed F		U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origii in, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	0- 1	 Race - Americ Black, White, 			
36	rs afte	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced				1 ☐ Yes 🌋 No	Specify:		5	Specify: Whi	te		
ş	ilied within 72 hours after deeth with the Maryland Hygiene. yther then "neturel", or Items 23e or 28e-f show ent, the Medical Examinat must be notified at	ed	15. Deceder	nt's Education		16a. Deced	ient's Usual Occupa	ation		16b. Kin	d of Business/Inc	dustry		
212	hin 7.	ple	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	life. I	kind of work done of DO NOT use retired	during most o f)	of working		-			
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Maryland 21215-0036	12 sh h and 7 Is m treum		19a. Informant's Name/Relations Lillian Mason		~				or Rural Route Numb e, Bethesd			Code)		
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ğ	ages in it		1 MBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		n State	cemetery, crer	natory or other plac es Cem ete		02/23/04					
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ä	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked ery injury of other treumatic evoluce.		1 Shu	11		l	anzansky 170 Rockv	GOLDBE Ville l	erg Memori Pike, Rock	al Ch ville	$\frac{1}{2}$, MD $\frac{1}{20}$	nc. 852		
			23a. Part LEnter the disease, o shock, or heart failure. Lis	r complications that	caused the de							Approximate Interval Between		
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89	ificate g phy as the	edic		- U										
Box	eath certific attending p i for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		Ectopic pregnancy			23	3d. Date of delive			
	deat	sicia	in the past 12 months? 1 — Yes 2 No		gnant at time of		Other (specify)				Month	Day Year		
O.	at the de 1 by the a stached	Phy	9 Unknown											
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Vital		e Co	OF Was soon referred to median						1 Tes	2 X No	1 ☐ Yes			
		o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ ▼No	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe		f Death <i>(Check only o</i> ing Home 5 ☐ Resi		MOther (Specifi	Assisted		
Division of	ig Phys ter this neral di	-	27. Manner of Death	28a. Date	e of Injury onth, Day Year)		28c. Injury	at	28d. Describe	how injury	occurred	ractify		
0	ath. arth. or: After ne funer	atio	1 Natural 5 Pendii 2 Accident invest	gation	inii, Day 16ai)	Injury	M 1 □	Yes 2 □ No	o					
<u>≅</u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 280. Plac	e of Injury - At	home, farm, stre	eet, factory, office		28f. Location (City or To		Number or Rura	Route Number,		
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	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier 1 XCertifyin (Check only 2 Medicel one)	Exeminer: On the	basis of examin	nowledge, death nation and/or inv	n occurred at the time restigation, in my op	ne, date and pointion, death	place, and due to the occurred at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)		
	To the within 2 To the Complet	Mec	29b. Signature and title of certifie		nner stated.		29c. License	number		29d. Date	signed (Month, I	Day, Year)		
			1 Am	V	2			5579			ary 22,			
	0		30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type		1313		. v. D.L.U	263			
			Susan J. Mill					ce, Be	ethesda, M	D 208	316			
	Sta		31. Date filed (Month, Day, Year,	32.	Registrar's Sign	nature								
	Registr	ar	FEB 24	2004	pera	B	Sparker	7						

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Yeer PAUL nmi LIVOTI 24/ 02/ 2004 12:45 PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Future Care of Chesapeake Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Devs Hours 1₽ M 2□ F 322-09-4669 Yrs Director 101 11/27/1902 New York Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health and Mentel Hygiene. Important: If Itam 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinal must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Howard Columbia 10e Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10085-4 Windstream Drive 21044 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1⊠ Yes 2 □ No If Yes, Give 1942 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1942~ 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1943 Specify: White à 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Sales 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gasper Livoti Jenny Abata 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 10085 Windstream Dr. Columbia, Maryland 21044
Date 20c. Location - City or Town, State Adrienne McDonough -niece 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from State 2/26/04 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Fecility Advent Funeral Service 21. Signature of Furteral Service Licensee 7211 Lee Hwy. Falls Church, Virginia 22046 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Cerebrovercular feedent /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the hunal-hand Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2X No weare Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 (No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Yes 2/21/10 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 102 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) PASADRNA 8021 RITCHIZ 31. Dete filed (Month, Day, Year) 32. Pegistrer's Signeture State FEB 27 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death And #28f.Per Phys.PGC 2-19-04 cr 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 02 12:476.4 Nurle Lowry 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Nursing & Rehabilitation Center Kensington Montgomery 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Month | Davs | Hours | Min. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Director 225-22-0208 08 03 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City. Town or Location 10b County 10d. Inside City Limits r is marked other then "netural", or Items 23a or 28a-1 show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No D. C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1236 Crittenden Street N.W. 20011 USA 12. Was Decedent Ever in U,S. Armed Forces?
1 Yes 2 □ No
If Yes, Give
Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plate Printer U.S. Government 12th permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 Is marked other any Injury or other traumer. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Chaple Lowry Fannie Cardwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sophia W. Smith-Weaver Grand Child 5510 40th. Ave. Hyattsville, Md. 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 15□ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-17-04 Brentwood, Md. Fort Lincoln 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee Marshall 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician. Immediate Cause (Final disease or condition resulting in death) /Medical a. <u>Cardio-Respiratory arrest</u>

Due to (or as a consequence of): Examiner brostate cancer with metastasis Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the buriel-trar P.O. Box 68760. Be Completed by Physiclan/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DUT, mesentheric vein thrombosis pancreatic mass 1 🗆 Yes 2 🗖 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Certification: To 1□ Yes 2□ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causes) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 20055362 02-10-04 suse of death (Item 23a) (T) pe, Print) / Livia (Elya HD) Kaisar personal towards of Sheet Rockville HD 20052 kl 703-359-7460 31. Date filed (Month, Day, Year) B2. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

FEB 1 9 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13,2004 **Physician** February Victor John Linnenbom 8:58 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Feb. 10, 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 490-12-4813 Missouri 89 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2624 Compass Drive 21401 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Myes 2 □ No
If Yes, Give
Year or Dates: 1942-70 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other treumatic event, the Mades ones. Naval Research College (1-4or 5+) 5+ Elementary/Secondary (0-12) Nuclear Laboratory Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward C. Linnenbom Lenora Joyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth M. Linnenbom / spouse 2624 Compass Drive Annapolis, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. 4-1-2004 Arlington, VA. 21. Signature of Funeral Service Lice (see 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Highway 11 ough Bowie, MD, 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Kessistant **Physician** /Medical Examiner av tevi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (onas a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 25. No Be 26. Place of Death (Check only one) Hospital: Certification; To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 27. Mann J Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the f Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide within 24 hours after To the Funeret Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certains 29c. License number 29d. Date signed (Month, Day, Year) D0058297 13 20 Name and address of person who completed ause of death (Item 23a) (Type, Print) OUNC-MO HOWERD Anne Arundel Medical Center Annapolis, MD. 21401 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 1 7 2004 Registrar

	ian cal	1. Decedent's Name (First, Middle, I				4			F	2. Date of De Month ebruar	у ^{Да}	, 2004	12:35
Exami	ner	4a. Facility Name (If not institution, g 3270 Elsa Avenu)			dorf	Location of	t Death		40	Charle	es County
Funeral				ge (In yrs. i	last birthday)		r 1 Year	If Under 2	24 Hrs.	B. Date of Bin (Month, Da	th y, Year,		Birthplace (State or F Country)
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show	5	10a. State 10b. County Md Charle	S	1	y, Town or Lo aldorf								10d. Inside City 11☑ Yes 2
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2 00 2		19a. Informant's Name/Relationship										or Town, State,	, Zip Code)
item 27 i	18	Vanessa Clayton 20a. Method of Disposition	<u> </u>	20b. P	3270 lace of Dispo emetery, cren				Da Da	rf, Md		ocation - City o	or Town, State
nt: If i		P☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		'	emetery, cren Mary				-17-0	4		nton, M	
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and a land		Immediate Cause (Final	lly one cause on each I	line.	i. Gynor sin								Onset and Dea
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Henry O. Lockhart Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-01211 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 ΑKG 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Henry 0. Lockhart February 13, 2004 15:18 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Riverdale
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. |
| Months | Days | Hours | Min. | August | 28, | 1970 Prince George's 5600 Riverdale Road Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) Social Security Number **Funeral №** M 2 F 216-02-9862 33 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or items 23a or 28a-f shov Exsoring roust be notified at 1 XYes 2 □ No |Maryland | Prince George's Hyattsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20784 6706 Stockton Lane USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married traumatic event, the Madical Extrate Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) al Hygiene. Roofer/Sheet Metal Worker Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clarence Lockhart Eunice Rickman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8936 River Island Drive, Savage, MD permit. Pages 1 and 2 Department of Health a Important: If item 27 li any injury or other tra QDCs. Clarence Lockhart/Brother Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition chesapeake Crematory 2/19/2004 1 ☐ Burial ② Cremation 3 ☐ Removal from State Beltsville, MD * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Juneral Service Licensee 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GUISHOT Wound disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed the burial-transit physician and Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Dayes 2 □ No 24a. Was an 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \boxtimes$ Other (Specify) At SCENE ٩ 1 XYes 2 ☐ No 28b. Time of Injury P M 28d. Describe how injury occurred Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural SUBTECT WAS SHOT 1 ☐ Yes 2 No 13/04 death. investigation I Director: / d in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Nymber of Rural Route Number City or Town, State) 5600 (11VCVALE IGA-3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide l or A nc Donald CIVEY LAG, MI To the Hospital within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier O.C.M.E. February 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 111 Penn Street, Baltimore, Maryland 21201 JACK W 31. Date filed (Month, Day, Year) State FEB 1 7 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Georgia Luther 2004 04, February /Medical 2:18 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F 244-46-7495 Director Oct.19, 1929 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ust be notified at P.G. Director Md. 1X Yes 2 □ No Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Items 23a 4022 Hanson Oaks Drive 12 should be filed within 72 more.
Ith and Mental Hygiene.
27 is marked other than "natural", or liems 23:
27 is marked other than "natural", or liems 23: 20784 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Key Punch Operator Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown 2 Odessa McClain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $4022\ Hanson\ Oaks\ Drive\ Landover,\ Md.\ 20784$ 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum Vendetta <u>Luther/daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. 2/12/04 Baltimore, Md. 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician we mon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit certificate be executed and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the 38 IF FEMALE 950 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) Ö the 9□ Unknown 9 Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 22 No Completed 1 Tyes 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

124 Yes 2□ No 24a. Was an autopsy .performed? certificate of Vital 2 🗆 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Date of Injury
Month, Day Year) 28c. injury at Work? 28b. Time of Medical Certification: 128d. Describe how injury occurred Division Injury 5 Pending investigation 1 Natural elestrian struct by vehicle death. 164 I Director: A 1 Tes 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, Late) after 4 Homicide 4022 within 24 hours a To the Funerel L Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely t Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 05, 2004 and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 LUM 31. Date filed (Month, Day, Year) FEB 1 7 2004 32. Registrar's Signature State Registrar

	1	For State Registrar	State of Marylan	id / Depa <i>Cei</i>	artment of H rtificate of	lealth and l Death		1169.110.	
Physician /Medical Examiner		Decedent's Name (First, Middle, Last) Edna a. Facility Name (If not institution, give so Shady Grove Ac		spita		or Location of Deat		Day Year 9,2004 4c. County of De	1915 M
Funeral Director		. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da		irthplace (State or Foreign Country)
Maryland	- 1	oa. State 10b. County Md. Montgon	1	ry, Town or Lo	Rockvil	le			10d. Inside City Limits M☐ Yes 2 ☐ No
after death with the Mar after 23a or 28e-f si inher must be indiffed Erneral Director	1	0e. Street and Number 9701 – Veirs D	rive		10f. Zip Code 208	850		10g. Citizen of What C	Country?
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 le marked other than "neturel; or Items 23a or 28e-f show other treumatic event, the Medical Examinar must be incitible at To Re Completed by Fineral Director	2	1. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
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d 2 should be filed within 72 hours aft the and Mental Hyglene. It is marked other than "neturel; or treumatic event, the Medical Examit To Re Commissed that the	ם 1	7. Father's Name (First, Middle, Last) John T. Doy	le	ПС	memaker	18. Mother's Na		o, Maiden Sumame) Schmidt	
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oermit. Pages 1 ar Department of Hea Important: If item i any injury or other ange.		1	emoval from State	Linco	natorv or other pla	etery-2/		Brentwood	
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that the death certificate be executed that the death certificate be executed ed by the attending physician and detached for use as the burial-transit bhysician/Madical Exeminat	Ical Examine	Sequentially list conditions, at any, leading to immediate ause. Enter Underlying Dause (Disease) of injury that initiated events resulting in death) Last	Due to (or as a consec	juence of):					
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To be a second of the second o								idence 6 Other (Sp how injury occurred	ecify)
To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	_ certifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy) 			City or To	(Street and Number or fi wn, State)	
e Hospital	adical		sician: To the best of my kno ner: On the basis of examina and manner stated.						
To the within 2 To the comple	3	29b. Signature and little of certifier			29c. Licen			29d. Date signed (Mor	
(15)		30. Name and address of person who co			Print)	060557		Feb. 22, 20	
State Registra		Dr.Leo Shue 31. Date filed (Month, Day, Year) FEB 2 3 2004	Registrar's Sign			т ноspi	cal, R	ockville,	MO.

	1 - For State of Maryland / Dep	eartment of Health and Mertificate of Death	Mental Hygiene 200	14 07719
Physician /Medical	1. Decedent's Name (First, Middle, Last) Jaqueline L. Lovett		2. Date of Death Month Day Yes	3. Time of Death
Examiner	4a. Facility Name (If not institution, give street and number) Doctor's Hospital	4b. City, Town, or Location of Death Lanham	4c. County of D	eath
Funeral Director	5. Social Security Number 018-22-3172 Oscial Security Number 6. Sex 7. Age (In yrs. last birthday 75 75 75 75 75 75 75 7	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. I	Birthplace (State or Foreign Country) ode Island
Loveth death with the Maryland ms 23a or 28a-1 show must be notified at	10a. State 10b. County 10c. City, Town or L	ocation Marlboro		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
6 Love 7	10e. Street and Number 307 Aden Court	10f. Zip Code 20774	10g. Citizen of What United St	_
7.4. 1036 ours after de Examiner is Examiner is 15 by Fune	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2☑ No Specify:	ecify Yes or No- Rican, etc.) 14. Race - A Black, W Specify: B]	
CAUTA (121215-06) ed within 72 hou ygiene. The madrial fit. The madrial fit. The madrial fit. The madrial fit.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Adm	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) inistrative	16b. Kind of Busine	ss/Industry
aryland; should be filed not Mental Hyg marked othe umatic event.	17. Father's Name (First, Middle, Last) Robert W. Williams	Ada	e (First, Middle, Maiden Sumame) Conston	
e, Mar 1 and 2 sh 1 and 2 sh 1 ealth and 1 m 27 ls m	19a. Informant's Name/Relationship (Type, Print) Roland Lovett/ Husband 20a. Method of Disposition 19b. Mail 307 A		Marlboro, MD 207	74
Baltimore, Maryland 21215-0036 Permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show miny injury or other traumatic event. The Madical Equilization and be pullified at ance. To Be Completed by Funeral Director	1 ▼Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn	matory or other place)	20c. Location - City 1/2004 Everett, Jenkins Funeral	MA
B760, sate be executed Wedgical Examiner the burial-transit and the burial-transit alical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	1		Approximate Interval Between Onset and Death ONE YEM
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IVISION Of Terrated and Terrate	examiner? 1 Yes 2 No Hospital: 1 Umpatient 2 EP/Outpatient 27 Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, stignificant building, etc. (Specify)	ont 3 DOA Cther: 4 Nursing Hor f 28c. Injury at Work? M 1 Yes 2 No	me 5 Residence 6 Other (Sp. 28d. Describe how injury occurred 28f. Location (Street and Number or Incity or Town, State)	
Hospita 24 hours Funeral stely filled	29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner, stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause(s) and manner and at the time, date and place, and du	as stated. ue to the cause(s)
To the within 2 comple	29b. Signature and title of certifier	29c. License number D 4 / 24	29d. Date signed (Mor	nth, Day, Year)
State	30. Name and address of person who completed cause of death (Item 23a) (Type, NORMAN SMITH NO 2905 M. 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Print) IT CHÉ//VI/LE RD	#104, BOWIE,	no 207/6
Registrar	FFR 2 4 2004 Keeper & And	netter .		

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OCME FEBRUARY 26, 2004 30. Name and address of person who company a cause of death (Item 23a) (Type, Print)	ely fill		(Check only 2 X Medical Exami	ner: On the basis of examination and/or	eath occurred at the investigation, in m	time, date and place y opinion, death occ	e, and due to the curred at the time, d	ause(s) and manner as late and place, and due	stated. o the cause(s)				
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J. Utfon Lock Maryland 21201			30. Name and address of person who co	omp and cause of death (Item 23a) (Tyr	e Print)								

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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated	ite Number,
29a. Certifier (Check only one)	
29c. License number 29d. Date signed (Month, Day,	cause(s)
Doo47534 2/26/04	cause(s)
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)	cause(s)
Wafik Zaki MD 920 Market St Denton, MD 21629	cause(s)
State Registrar 31. Date filed (Month, Day, Year) Registrar 32. Registrar's Signature	cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0545 February 22 2004 Dottie L. Miles /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Mariner Health of Forest Hill Forest Hill Dete of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🖾 F ั 1908 95 218-22-5457 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or iteme 23e or 28a-f ehow enty injury or other traumatic event, the Medical Examiner must be positived and entered and entered and entered 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Forest Hill Be Completed by Funeral Director Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21050 USA 109 Forest Valley Drive Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes Give Specify: White 3X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) American Eagle Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Lawson Robert L. Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Summer Fields Ct Lutherville, MD 21093 Robert Raglin/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/26/2004 1 □ Burial 2 □ Cremation 3 KRemoval from State Floral Gardens Memorial Pk High Point, NC * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part . Enter the disease, or complications that cause it shock, or heart failure. List only one cause on each line Approximate Intervat Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No director, page 2 should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Whiknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 D No 1 🗌 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 28a. Date of Injury (Month, Day Year) 27. Mann of Death the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After atural 5 Pending within 24 hours after death.

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		ı	For	State of Marylar	nd / Depa	artment o	f Health and		giene	
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920	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "naturel", or items 23e or 28e-f ehow event, the Medical Examinar must be notified at	by Funerai	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	i	If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	to Rican, etc.)	Specify:	
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Amended#10c, 10fperFH FCHD SICertificate of Death 2/19/04 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Eleanor W. Miller February 13,2004 6:40P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Dec. 28, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 M 250XF 85 Yrs. 1918 Maryland Director 217-05-9486 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic svent, the Modical Examiner must be notified at 1 Yes 2 No Maryland Frederick Frederick Thurmont Director 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 21788 21788 U.S.A. 23 Altamont Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Rfack. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 white 1 Tes 2 No Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own home 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H Nannie C. Wachter Roy E. Weller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ges 1 and 2 shit of Health and 23 Altamont Avenue, Thurmont, Maryland Dennis Miller - Son 21788 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department of Importent: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Blue Ridge Cemetery 2-16-2004 Thurmont, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee Maron Canulle 104 E. Main Street, Thurmont, Maryland 21788 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition EMBOLISM **Physician** -Mon resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed ig physician and as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical use a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | the signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 pe 1 🗌 Yes 2 000 3 Probably 4 Unknown ailund Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 250No certificate has page 1□ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes 1 X patient ပ္ 2 ER/Outpatrent 3 DOA After this Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No Accident investigation within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2 804 of person who completed cause of death (Item 23a) (Type, Print) ICKEM, un1)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

2004

State of Maryland / Department of Health and Mental Hygiene [] [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** В. McGilvrey, III February 17. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Backus Drive Bowie Prince Georges 12114 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10XM 2□F Director 48 24,1955 215-66-9735 November Oregon Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nent of Health and Mental Hygiene.
nent if item 27 is marked other than "natural", or items 23s or 28a-4 show and it item 27 is marked other than "natural", or higher items and on notified any or other traumatic event, ma Medical Examinia 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County ral', or items 23a or 28a-f ahow Examiner must be notified at 1 Yes 2 No Maryland Prince Georges Bowie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12114 Backus Drive 20720 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify White Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Computer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Teuebaugh Frank B. McGilvrey, Jr. Marilyn Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health ar Important: If item 27 Is any injury or other trau QDGs. Lee McGilvrey/ Wife 12114 Backus Drive, Bowie, Maryland 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory Waldorf, Maryland 2/19/2004 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 12 16000 Annapolis Road, Bowie, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ulo resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examiner physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medicai as the l attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 XYes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 1 ☐ Yes 2 🗽 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 WIN 1018219 02 ton 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Staal, M.D. 1221 Mercantile Lane, Largo, Maryland 20774 31. Date filed (Month, Day, Year) FEB 19 2004 32. gistrar's Signatur

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Mary		artment of F		Mental Hygier	1e 2001	<u>+ 07</u> 72	
Physi /Med		Decedent's Name (First, Middle, La: JOHN F. MARTIN	st)					Day Year	3. Time of Death 5:50 Ai	
Exam	iner	4a. Facility Name (If not institution, given Genesis Elder 5. Social Security Number 6. S	Care - The	Pines	East If Under 1 Year		8. Date of Birth	4c. County of Deat Talbot 9. Birt		
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ath with the Marylan 123e or 28a-f show	ctor	10a. State 10b. County MD TALB		EASTO					10d. Inside City Limit	
with th	I Director	10e. Street and Number 610 DUTCHMAN'S L	ANE		10f. Zip Code 2160	1	10g. (Citizen of What Co	untry?	
after de or Itams	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 🏋 Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: WHITE		
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should be nd Mental marked c	To	J. FRANCIS MARTI 19a. Informant's Name/Relationship (19b. Maili	ng Address (Street		A C. SMITH	y or Town, State, 2	(ip Code)	
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I ne law requires that the death certificate be executed to the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. Due to (or as a co	oregnancy]Ectopic pregnancy] Other (specify)			23d. Date of deli	very Day Year	
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To tha Hospital or Attanding Physician: within 24 hours after death. To tha Funeral Diractor: After this certifics completely filled in by the funeral director, t	Certification;	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Natural 5 Pending investigation 6 Could not by determined		- At home, farm, str	Worl M 1□	yat k? Yes 2 □ No	28d. Describe how inj 28f. Location (Street a City or Town, Sta	and Number or Ru	ral Route Number,	
To tha Hospital or within 24 hours afte To tha Funerel Dir completely filled in	edicai C	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/or in	n occurred at the tin vestigation, in my of	ne, date and place pinion, death occu	, and due to the cause(gred at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)	
To th within To th compl	We	29b. Signature and title of certifier > Pslymer	n MO		29c. License			pate signed (Month		
		30. Name and address of person who F. Seymow MD,	completed cause of death	ild Aver	Print) THE, Ea	sten, M				
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's							

State of Maryland / Department of Health and Mental Hygiene $200 \, \mu$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician <u>3:3</u>5 Рм Thomas Claude Mattingly 12, February 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 44526 Clarks Landing Rd. Hollywood St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 MM 2 □ F 220-16-4977 79 Director Maryland December 21, 1924 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Marylar I and Mental Hygiene.
I se marked other then "natural", or itams 23e or 28e-f show reumatic event, II e Madical Exactioner initial te positived at St. Mary's Maryland Hollywood 1 ∏Yes 2KNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44526 Clarks Landing Rd. 20636 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. 1 ZYes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farm Tobacco Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Leo Mattingly Grace Magdeline Long Pages 1 and 2 should nent of Health and Men 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Mary E. Pollard - Sister P.O. Box 481 Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of P
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cemetery 2/18/200421. Signature of Funeral Service 22. Name and Address of Facility
Mattingley-Gardiner Funeral
P.O. Box 270 Leonardtown, N nurue 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a con; Attero sclustu Grasio vasalo Duan **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 8 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1XYes Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 2 No r 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Alter Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director. 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) W. Roache, MD P.O. Box 186 Mechanicsville, MD 20659

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, D

s Signature

200 32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 07728 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Charles Raymond Mowery, II P^{M} 12:31 February 19, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's 18861 McKay's Beach Road Valley Lee If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 1 → M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 51 Yrs. Director 214-60-3490 August 20, 1952 Puerto Rico Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral', or iteme 23a or 28e-f show Examiner next be notified at 1 ☐ Yes 2X No St. Mary's Valley Lee Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18861 McKay's Beach Road 20692 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 TYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) 2 College (1-4or 5+) Chimney Cleaning Chimney Sweep and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Raymond Mowery, I Hilda Josephine Bagnoli 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other treu once. P.O. Box 95, Valley Lee, MD 20692 Hilda J. Mowery/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St. George's Cemetery 2/24/2004 Valley Lee, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityMattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 20650 umen 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as contract or property direct. shock, or heart failure. List only one cause on each line Onset and D th Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 BNatural 5 Pending 1 TYes 2 TNo investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ù a pelii 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. After death. To the Hospitel or Attend within 24 hours after dealt To the Funerel Director:

death t

Pages 1 and 2 should be filed within 72 hours after

Hygiene.

Baltimore, Maryland 21215-0036

Box 68760.

24035 Three Notch Road, Hollywood, Maryland 20636 Jarboe, Dr. James Registrar's Signature State Registrar

person who completed cause

30. Name and addr-s

State of Maryland / Department of Health and Mental Hygiene

				•	cate of Death		Reg. No. 2016	07729	
	Physician	Decedent's Name (First, Middle, Less	•	M		2. Date of Dea	Day Year	3. Time of Death	
	/Medical	Louis		Moore			ry 20 200		
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	Funeral Director	3/9-18-0804	7. Age (In yi	s. last birthday) If Mo	Under 1 Year If Under 24 H Inths Days Hours Mi	n. 8. Date of Birt Mar. 10	year) 15 Mar	place (State or Foreign intry) yland	
	D .	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Location	n			10d. Inside City Limits	
	with the Marylan a or 28a-f show be notified at Ofrector	Maryland Calv		Huntin				1 ☐ Yes 2 ☑ No	
	the 128a	10e. Street and Number			Of. Zip Code		10g. Citizen of What Cou	intry?	
	s 23a or	680 Ponds Wo		110	20639		USA		
020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any follury or other traumatic avent, it a Medical Examinar must be notified at ance. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Decedent of Hispenic Origin? s, specify Cuban, Mexicen, Pue r'es 2 XNo <i>Specify:</i>	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify: B1 a	, etc.	
5-0	72 h	15. Decedent's Edu (Specify only highest grad		16a. Decedent's (Give kind	s Usual Occupation of work done during most of w IOT use retired)	16b. Kind of Business/Industry			
2121	d within giene.	Elementary/Secondary (0-12)	College (1-4or 5+)		e Maker	·	Own Home		
pu	be filed tal Hyg d othe avent,	17. Father's Name (First, Middle, Last)	0 1		1	ame (First, Middle,			
ylaı	Menta arked atic a	John	Gardne	-	Mary		Carle		
, Mar	und 2 sho alth and 27 is me er traum	19a. Informant's Name/Relationship (7) Barbara Foreha:	ире, Print) nd/Daughtei		unic Ave. (
Baltimore, Maryland 21215-0020	ages 1 and of Henrit: If Item	20a. Method of Disposition ↑ Nation 1 Communication 2 Communication 3 Commun		Place of Disposition cemetery, cremator	e Mane Chr. C	Date 1,2/25/0	20c. Location - City or T		
Balti	pemit. I Depertm importar any inju	21. Signature of Funeral Service Licens		22. Nat 1 4 5	ne and Address of Facility Se 1 Dares Beac nce Frederic	ewell Fu ch Road	neral Hom	e	
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that caused the de					Approximate Interval Between	
)	Physician /Medical Examiner	CTI ON ACCIOENT	Onset and Death						
	filcate be executed a physician and as the burial-transit edical Examiner			PSN-0 U		an 1	ACCIOENT		
ó	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit / Physician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	540 (0	(or as o consequent	o o.,.		1		
68760,	ate be hysici the bu	that initiated events resulting in death) Last	Due to	(or as a consequenc	e of):				
9 ×	e as t		4						
Вох	ath ce titlend for us		J						
	nat the death ce d by the attendi letached for us: Physiclan/	Part II. Other significent conditions con	ntributing to death but not re	sulting in the underly	ying cause given in Part I.		obecco use contribute t		
P.0	that the ned by detac	in the second se				1 🗆 ١	′es 2 El No 3 □ Pro	bably 4 ☐ Unknown	
Records,	The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Completed by Physician/Medical Exami					24a. Was a perfor	med? av	fere autopsy findings rallable prior to empletion of cause death?	
Ě	nysician: The law his certificate has b I director, page 2 s		1.17	es 21/2No 11	□Yes 2□No				
Vital	entifica octor, l	25. Was case referred to medical examiner?	eath (Check only or	78)					
<u>~</u>	Physician: rthis certific ral director,	1 ☐ Yes 2 127 No	-	ence 6 □Other (Specia	5/)				
Division of	ath. r: After tl ee funera	27. Manner of Death 1	28d. Describe h	ow injury occurred					
Divis	tal or Attending P rs after death. al Director: After t led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	home, farm, street, f ify)	e, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number City or Town, State)					
	29a. Certifier (Check only one)					ause(s) and manner as a ate and place, and due t	telied o the cause(s)		
	Withir Comp	29b. Signature and title of certifier	ber 29d. Date signed (Month, Day, Year)						
N					D5818	4	2-20-	2004	
	15	30. Name end address of person who co	ompleted cause of death (Ite	em 23a) (Type, Print)		Bowie	 . мр 2072	20	
	1D	31. Date filed (Month, Day, Year)	32. Registras Sign	nature		DOMTE	, FID 2072		
	State	FEB 9 S	2004 4000	as the	Locally 1				

			1 - For State Registrar	State of Ma		artment of ertificate of			giene Reg. No. 200 L	07730
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Emma Burnette Mo	cNeil				2. Date of Dea Month Feb 22	Day Yeer	3. Time of Death 3:00A M
}	Examir		4a. Fecility Name (If not institution, give s Bradford Oaks Num 5. Social Security Number 6. Sex	rsing Home	(In yrs. last birthda	C1i	or Location of Dea nton r If Under 24 Hr	ath	Prince G	eorge's
W.	Funeral Director			M 2FIF	67 Yrs.	Months Days				inthplace (State or Foreign Country)
	h the Marylan or 28e-f ehow s notified at	irector	10a. State 10b. County Maryland Prince Ge 10e. Street and Number	eorge	10c. City, Town or I	t Washin	gton	T	10g. Citizen of What C	10d. Inside City Limits 1 Yes 2 No
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28e-1 show or other traumatic event, the Medical Examinat must be notified at	by Funeral Director	1706 Portland Ave	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 □ NK If Yes, Give A.X Year or Dates:		. Was Decedent of	ban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	Black, Wh	encan Indian,
Maryland 21215-0036	filed within 72 ho Hygiene. other than "naturent, ina Medical	e Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1.2 17. Father's Name (First, Middle, Last)	cation e completed) College (1-4or 5+	(Giv	edent's Usual Occi e kind of work don DO NOT use retir	eduring most of w	orking ame (First, Middle,	16b. Kind of Business Group Hea	
larylan	2 should be and Mental is marked caumatic even	To Be	Henry Burnette 19a. Informant's Name/Relationship (Type				nt and Number or F		r, City or Town, State,	
Baltimore, N	permit. Pages 1 and Department of Health Importent: If Item 27 eny injury or other tr 9068.		James McNeil (hu 20a. Method of Disposition 1 Depurial 2 Cremation 3 Review (Specify)		20b. Place of Disp cemetery, cri	osition (Name of ematory or other pl	ace) Feb 27	,2004	20c. Location - City o	ryland
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Service License	2 (Mo		2. Name and Add		e Funera	I Home, Inc	6633 01d yland 20735
>	Physician /Medical Examiner		23a. Pañí. Enter the disease, or fomplic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line	he death. Do not e.	Th.	and such as cardia		rest,	Approximate Interval Between Onset and Death M ON
8760,		ical Examiner	Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnan □ Other (specify)	су	-24	23d. Date of de Month	blivery Day Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cause g	iven in Part I.		obacco use contribute t	to the cause of death?
al Record	n: The law re icate has be r, page 2 sh	Completed						24a. Was autop perfor 1 Yes	sy prior to	utopsy findings available completion of cause of
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 22 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day	28b. Time	of 28c. Inju	ther: Nursing		ne) lence 6 Other (Spa ow injury occurred	ecify)
Divis	ospital or Attending lands after death. unerel Director; After ly filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	treet, factory, office		City or Tow		- 11:30: - W 1: - 1: -		
	To the Hospital or within 24 hours affer To the Funerel Dir completely filled in	Medical	29a. Certifier Check only one) 29b. Signature and title of certifier	sician: To the best of ner: On the basis of e and manner state	examination and/or i	nvestigation, in my	ime, date and plac opinion, death occ se number	curred at the time, o	ause(s) and manner a date and place, and du 29d. Date signed (Mon	e to the cause(s)
			30. Name and address of person with	eleted cause of dea	ath (Item 23a) (Type	. Print))1943	#100	2/24/2	04 d (40)
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 4 201		's Signature	bergs	NW (US	105	T. Wash	30 49

			1 - For State Registrar	State of Ma	-	Departmei <i>Certifica</i>			nd Men			2001	+ 07731
	Physici	an	Decedent's Name (First, Middle, Las		_					Date of Dea Month	Day	Year	3. Time of Death
T T	/Medic	al	Irvin Joseph 4a. Facility Name (If not institution, give	Miller,	Sr.	Ab Cib	Tourn	r Location of		eb. 2	2,	2004 County of Deet	11:05ď
100	Examin	er	12584 Hatton C				wbu		Dodu		10.	Char	
	Funeral		Social Security Number 6. Security Number	7. Age	(In yrs. last bir		r 1 Year			Date of Birth Month, Day	Year)		thplece (State or Foreign
·	Director		219-20-7023	2 M 2□ F	69	Yrs.	Days	Tiodis	Jί	ıly 1	8 1	.934	MD
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location				<u> </u>			10d. Inside City Limits
	Mary -feho	tor	MD Charl	es	N	lewburg							1 ☐ Yes 2 No
	or 28s	irec	10e. Street and Number				p Code			1	0g. Citi	zen of What Co	ountry?
	23a c	ralD	12584 Hatton Cr				2066					U.S.	
	er dez	une	11. Marital Status 1 ☐ Never Married 2 ☼ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N		13. Was Deci	edent of H ecify Cuba	ispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- n, etc.)		 Race - Ame Black, Whit 	
36	urs aft	by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 N 0	Specify:				Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. ed other then "natural", or tleme 23a or 28a-f ehow event, the Medical Examinatment be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Decedent's Us	ual Occup	ation	of working		16b. Ki	nd of Business	/Industry
2	hen hen	mple	Elementary/Secondary (0-12)	College (1-4or 5-		(Give kind of w life. DO NOT		1)				Power	Plant
	filed w Hygiei other ti	e Col	17. Father's Name (First, Middle, Last)		та1	ntenar	ice	18. Mother	's Name (Fir	st, Middle, i	Maiden	Sumame)	
ano	should be filed within a Mental Hygiene. Thanked other then matic event, Item		Morris Miller						e Gol			,	
Maryland	S E S	1	19a. Informant's Name/Relationship (7 Shirley Miller/			. Mailing Addres							Zip Code) d. 20664
	s 1 and 2 f Health item 27 other tr		20a. Method of Disposition		20h Place of	Disposition (Nary, crematory or	me of		Date			cation - City or	
E	Pages nent of int: If th		1 Surial 2 Cremation 3 □ 1 Donation 5 □ Other (Specify			Ghost			/25/0) 4	Iss	ue, Mo	i.
Baltimore,	permit. Departn Imports eny inju	21. Signature of uneral Service Licepees MOO945 AREHART - ECHOL'S FUNERAL HOME, PA P.O. Box 567 LaPlata, MD 20646											
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the deeth. Do	not enter the mo	de of dyin	ig, such as c	cardiac or res	spiratory arr	est,	0040	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	3	_	PIRAT	OR	Y	FAI	IUR	3		Onset and Death Fをい カインS
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):	,				- 0		0.44.24.0
	_xammer	3r	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):	XL	LUNG CANCER					8 HOWITS
	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	_	COF								HARY YEARS
ó	cate be executed obysician and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a								-	LA US AD!
8760,	ate be nysicia he bu	icai	•	d	ACC	UD							HONT YEARS
9	Physician: The law requires that the death certifica this certificate has been signed by the attending phraid director, page 2 should be detached for use as I	Physician/Med	IF FEMALE:	00-14	4								
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1	Fetal death	3 ☐Ectopic 5 ☐ Other (s		,			2	23d. Date of del Month	livery Day Year
P. O.	that the death certific ed by the attending p detached for use as	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ine or death	2 🗆 O(I)ei (:	pocity)						
	igned b	by Pt	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	n the underlying	cause give	en in Part I.		23e. Did tol	bacco u	se contribute to	the cause of death?
rds	w require been sig should b	ed b								1 🗆 Ye	es 2[□No 3□Pr	obably 4 donknown
Records,	law requas been 2 should	Completed								24a. Was a autops		prior to	utopsy findings available completion of cause of
H	The law cate has page 2	Соп								perforr 1 ☐ Yes :		death?	
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	00	of Death (Ch	- 6			
of	Phys	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									city)		
ion	27. Manner of Death 1 Natural 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? M 1 Yes 2								10				
Division of Vital	er des rector by th	28a. Date of Injury 28b. Time of 28c. Injury a Work? 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 9 Uniform the pullding, etc. (Specify) 28a. Date of Injury 28b. Time of 28c. Injury a Work? 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 9 Uniform the pullding, etc. (Specify)								Location (SI City or Town			ural Route Number,
Ö	ital or irs afte ral Dir led in				,							·	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best on niner: On the basis of and manner state	examination an	e, death occurre d/or investigation	d at the tin n, in my o	ne, date and pinion, death	d place, and o h occurred a	due to the ca t the time, d	ause(s) ate and	and manner as place, and due	s stated. to the cause(s)
	To the comp	Σ	29b. Signature and title of certifier	0 00	a		9c. Licens		7	2		e signed (Mont	
<i>F</i> .			100	7 1				2117			2	124/0	4
1	RIA		30. Name and address of person who	completed cause of de	ath (Item 23a)	^{(Туре, Р} 346	0 01	ld Wa	shing	ton	Rd.	Waldo	orf,MD
	Sta	te	NIRAW. 31. Date filed (Month, Day, Year) FEB 2 4	32. Redistra	r's Signature	has	· ,						20602
	Registi		FEB 24	2004	us Di	A PARTY OF THE PAR	Ura						

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Vear **Physician** McNamer 1:07 PM Eugene February 20 2004 homas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown

| Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser | Houser Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 ☐ F 55 Maryland Yrs. 218-50-4913 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner rust be notified at Maryland Washington Clear Spring 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 11627 Dam #5 Road 21722 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No 1969—
If Yes, Give Year or Dates: 1971 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. and Term 27 is marked other then "natural", or Ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No white Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) correctional officer 0 - 12state 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William McNamee Jean Elliott P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) thealth in the straight in the Linda McNamee - wife 11627 Dam #5 Road, Clear Spring, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of t-Important: if Ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown Crematory ¹ 4 □ Donation 5 □ Other (Specify) Hagerstown, Maryland Minnich Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kali 415 East Wilson Blvd., Hagerstown, Maryland 21740 Carelie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) E985 Enysician noma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. the 9 Unknown 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 119 2 No 1∏Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy perform this certificate 1 ☐ Yes 2 - No Division of Vital Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 🗌 Yes 2 No 1 __npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 🗀 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide 29a. Certifier (Check only one) 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and add of death (Item 23a) (Type, Print) 83 32. Registrar's Signature State Registrar

		1 - For State Registrar	State of	Maryland / De	partment of Health ertificate of Death	and Mental Hy	giene Reg. No. 200 L	· · · · · · · · · · · · · · · · · · ·
Physic /Medi Exami	ical	1. Decedent's Name (First, Middle, L Leono Pec 4a. Fecility Name (If not institution, gi	arl N	<u>ladden</u>	4b. City, Town, or Location	2. Date of De Month Fe buay	Day Year	1
		Washington County			Hagerstown		Washingt	on County
Funeral Director		5. Social Security Number 6. 219-74-3238 Usuet Residence of Decedent	Sex 7. 1 M 2 AF	Age (In yrs. last birthda 85 Yrs.	y) If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. Date of Bin Min. (Month, Da August	9. Bir 2, Year) 18 1918 We	thplece (State or Foreign ountry) est Virginia
death with the Maryland ma 23a or 28a-f show Entable for rediffed at	ctor	10a. State 10b. County Maryland Washin	ngton	10c. City, Town or Hagersto				10d. Inside City Limits 1 ☐ Yes 2 No
h with the 23a or 28 at be not	Funeral Director	10e. Street and Number 11320 Lakeside Di	rive		10f. Zip Code 21740		10g. Citizen of What Co. U.S.A.	100
ē 2 Z	by	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedd Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? X No	. Was Decedent of Hispanic C tf Yes, specify Cuban, Mexic 1 Yes 2X No Specify		14. Race - Ame Black, Whit Specify: Wh	e, etc.
d within 72 hours at giene. or then "natural", or	Completed	15. Decedent's Elementary/Secondary (0-12)		(Gir	edent's Usual Occupation we kind of work done during mo DO NOT use retired)	ost of working	16b. Kind of Business.	/Industry
D D	Co	8			Owner		Service St	ation
d be ental	To Be	17. Father's Name (First, Middle, Las			Ber	her's Name (First, Middle, rtha Snyder		
nd 2 salth an 27 ie r		19a. Informant's Name/Relationship David Wayne Rize		8206	Dam No. #4 Rd.	. Williamspo		, ,
		20a. Method of Disposition 122 Surial 2 Cremation 3 (4 Donation 5 Other (Spec			ematory`or other place)	Teb. 14, 200	20c. Location - City or 4 Cumberlan	
permit. Page Department of Important: If eny injury or ance.		21. Signature of Funeral Service Lice	insee		22. Name and Address of Fact 331 Eastern B			
Physician /Medical Examiner		23a. Part 1. Enter the discase, or cor shock, or heart a lure. List only Immediate Cause (Final disease or condition resulting in death)	a Car	is the death. Do not entries. as a conseque ce of):	nter the mode of dying, such a	as cardiac or respiratory ar	100	Approximate Interval Between Onset and Death
te be execuled ysician and he burial-transit	Exar iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	as a consequence of): as a consequence of):				
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The law ate has b page 2 sl	Completed					24a. Was autop perfor 1 Yes	sy prior to a med? death?	itopsy findings available completion of cause of 2 \(\text{No} \)
Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		04	ce of Death (Check only o	ne)	
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or Atten after deat Director: in by the	Certification:	2 Accident investigatic 3 Suicide 6 Could not l 4 Homicide determined		f Injury - At home, farm, s , etc. <i>(Specify)</i>	reet and Number or Rural Route Number, n, State)			
To the Hospital within 24 hours a To the Funeral completely filled	edical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the bominer: On the basi	is of examination and/or	ath occurred at the time, date a nvestigation, in my opinion, de	and place, and due to the coath occurred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
To th Withir	Me	29b. Signature and title of cardie	ber	_, Do, FAC	29c. License number HYU 88	Y F	29d. Pate signed (Month	13 th 200 4
5H-Z				of death (Item 23a) (Type etam St. Ha	gerstown, Mary	1		(10)
Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Reg	pistrar's Signature	Susuwii, Mary	land 21740		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 24,2004 Month **Physician** February 0845 McLAUGHLIN ELLEN E. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Berlin 1 Meadow Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7 - 4 - 1 4 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔭 89 Yrs. 063-05-2151 NY Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County ral', or items 23a or 28e-f show Exemiter must be notified at 1 Yes 2 □ No Berlin Md. Worcester Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA 1 Meadow Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White er than "natural", c φ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary Education 12 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event sine. Be Louis Hamilton Elizabeth Α. Barnett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13 Rockside Rd. Ocean Pines, Md. 21811 Ken McLaughlin Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/☑Burial 2 □ Cremation 3 ☐ Gemoval from State Brooklyn, NY Cypress Hill 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ullrich Funeral Home Berlin, Md. 21811 23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHE /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Arten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed; 2 No 1 Yes 2 No 1 Yes this certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) the funeral 27. Manyler of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a 1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H0053717 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. (c , MO 21811 Berun Healthouse I MATZONIE 32. Digistrar's Signature 31. Date filed (Month, Day, Year) State **FEB 24** 2004 Registrar

			For State Registrar	State of Marylan	•	artmen rtificate			d Ment	al Hygie	Z 0 H	4 07735
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	/Medic Examin		4a. Facility Name (If not institution, gire					Location of D		BRUARY	14, 200 4c. County of De	
	LAGITITI		Memorial Hospita	al & Medical Ce	enter		Cumbe	rland			Alle	gany
ī	Funeral Director		5. Social Security Number 6.	Sex 7. Age (In yrs. 1 ☐ M 2 🖾 F 84			1 Year	If Under 24 I	Min. (A	ate of Birth fonth, Day, Ye		irthplace (State or Foreign Country) ryland
			Usual Residence of Decedent						01	700717	20 114	
	how		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation						10d. Inside City Limits
	Ba-f-	cto	MD Alleg	any	LaVale	2						1 Tyes 2 No
	or 28	Director	10e. Street and Number			10f. Zip				10g.	. Citizen of What	Country?
	ath v	rai	77 National Hig				1502		0 (0	()	USA	nerican Indian,
	lter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 □Yes 2X No	1.5.	If Yes, spec	ofy Cubar	spanic Origin' n, Mexican, Pi	Puerto Rican	, etc.)	Black, Wh	
2	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2X No	Specify:			Specify:	White
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7 2	ould Men narke	P_C	Hillary	Н.	Harts		(0)	Ida		G.		sh
Ma	nd 2 should be filed within 72 hours after death with the Maryland and manyland Hydiene. 27 is marked other than "natural", or items 23a or 28a-f show it traumatic event, the Macical Examinar maint be natified at		19a. Informant's Name/Relationship Cletus M. Mallow			-					ity or Town, State D 21502	
ນົ	a he a		20a, Method of Disposition	20b. F	Place of Dispo	osition (Nan	ne of		Date		c. Location - City of	or Town, State
2	Pages nent of fi int: If its iry or of		MSBunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	_Hemoval from State	cemetery, cre Llcrest		_	1	2/17/2	004 C	umberlan	d MD
Dallillio	artme ortan injur		21. Signature of Funeral Service Lice									1 Home, P.A.
Ď	permit. Departinimporta eny injt		1 Kihut C	adems							and, MD	21502
*	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									Approximate Interval Between Onset and Death 1 week	
	/Medical Examiner	X	disease or condition resulting in death)	Due to (or as a consec	quence of):							1 WCCK
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. DOX	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3	□Ectopic pr □ Other (sp					23d. Date of d Month	delivery Day Year
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Ĕ	: The law cate has t page 2 s	E							1	autopsy performed Yes 2	d? death	es 2 No
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	Physician: this certificantal director, I	2	1 Yes 2 No		ER/Outpatie			4 Nutsir	ing Home	5 🗆 Residenc	e 6 □Other (Sp	pecify)
ō =	ng Pl ster th		27. Manner of Death 1 S Natural 5 □ Pending	28a. Date of fnjury (Молth, Day Year)	28b. Time of Injury		Bc. Injury Work			Describe how	injury occurred	
VISIO	tendi leath. tor: A the fu	cati	2 Accident investigate 3 Suicide 6 Could not	he -		М		res 2 □ No		(0)		
2	itel or At rs after or al Directed in by	Certification:	4 Homicide determine		ify)	treet, lactory	/, office			City or Town, S		Rural Route Number,
	To the Hospitel or Attending Phys within 24 hours atter death. To the Funeral Director: After this completely filled in by the funeral di	edical		Physician: To the best of my kn iminer: On the basis of examin- and manner stated.								
	To the within To the COMP	ž	29b. Signature and title of certifier	Λ		290	c. License	number		29d	. Date signed (Mo	nth, Dey, Year)
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	nds		30. Name and address of person who Robustiano J. Ba				ri a 1	Avenu	ie. Cii	mherla	nd. MD	21502
91		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign					,		110	
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	Physici	an	1. Decedent's Name (First, Middle, La			McGee				2. Date of Dea Month	Day	Yea	3. Time of Death
	/Medic	al	Madaline 4a. Fecility Name (If not institution, gi	Mary		4b. City. To	own or l	ocation of	Death	Ud	4c.	County of De	
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	Funeral			Sex 7. Age (In yrs. last t	birthday)	If Under 1 Months D	Year Days	If Under 2	4 Hrs.	8. Date of Birth	2	9.1	irthplece (State or Foreign Country)
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	and w.	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation							10d. Inside City Limits
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	n the	lrec	10e. Street and Number			10f. Zip Ci	ode				10g. Citiz	en of What (Country?
	th wit	alD	2029 Bedford Ro	ad			150					JSA	
2-003e	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show spirighty or other traumatic event, the Medical Examiner must be rediffed an once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑No If Yes, Give Year or Dates:		Vas Deceder Yes, specify		panic Orig , Mexican, Specify:	in? (Spe Puerto I	cify Yes <i>o</i> r No- Rican, etc.)		4. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
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2	should nd Me mark mati	2	Arthur Christn 19a. Informant's Name/Relationship		9b. Mailin	g Address (S	Street a			i Route Numbe	r, City or		
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e,	es 1 a of Hea ritem		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3	20b. Place	of Dispos stery, cren	sition (Name natory or othe	of er place	,	D	ate	20c. Lo	cation - City	or Town, State
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	h 21		30. Name and address of person wh	o completed cause of death (Item 23:	sa) (Type. Set	Print)			(-	tezo	, ,	2	2/502
/	h Ks	ato	31. Date filed (Month, Day, Year)	32. Registrar's Signature		ont	100	VR	اردر.	1620	× C	win	perland Md
	Regist	ate rar		104 house	6	hoo							

DHMH 17 Rev 1/2001

ORIGINAL

			Please I	State of Marylan				-	_	
			State Registrar		Cei	rtificate of	Death		og. No. 200L	
	Physicia /Medic	an	 Decedent's Name (First, Middle, Last) Elizabeth Jean Ma 	rtin				2. Date of Deat Month Februar	y 15, 2004	3. Time of Death 10:00 A M
	Examin		4a. Fecility Name (If not institution, give s 4907 Boiling Brook			4b. City, Town, Rockv	or Location of Death		4c. County of Deer	
	Funeral Director		5. Social Security Number 6. Sex 1	M 2 F 7. Age (In yrs.)	last birthday) Yrs.	tf Under 1 Year Months Days		8. Date of Birth (Month, Day, February	9. Bird 22,1935 West	hplace (State or Foreign ountry) Virginia
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits
	the Man 28a-f sh	rector	Maryland Montgome	ry Ro	ckvill	.e		1	0g. Citizen of What Co	1 ☐ Yes 2 🔀 No puntry?
	h with 23e or	ai Di	4907 Boiling Brook	Parkway		20852		τ	nited Stat	es
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amount in items 23a or 28a-f show are injury to other traumatic event, It a Medical Examinar must be notified at another.	by Funeral Director	11. Marital Status 1 ☑ Never Mamied 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	 12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 	1	Was Decedent of If Yes, specify Cui 1 ☐ Yes 2X No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	ithin 72 houne. ne. nen *nature	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)		(Give	DO NOT use retir	a during most of work ad)		16b. Kind of Business	t
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ry la	hould id Men marke matic	ို	Thomas B. Martin 19a. Informant's Name/Relationship (Ty)	pe. Print)	19b. Maili	ng Address (Stree	Ezma J. (. City or Town, State,	Zip Code)
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Baltimore,	permit. Pa Departmer Important any injury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service icenses	99	Ro					uneral Home/ venue,
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Division	el or Attend s after death si Director: , ad in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif		reet, factory, office	Ð	28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospitel of within 24 hours after the Funerel D completely filled in	edical (ner: On the best of my known of the basis of examina and manner stated.						
	To th within To th comp	Me	29b. Signature and title of certifier	M	MA		nse number	2	9d. Date signed (Mon	11 12
	13		30. Name and address of person who co	ompleted cause of death //ten	n 23a) (Type		3457		February 1	6, 2004
			Nakul Goyal, M.D.	3801 Internat	ional		211, Silv	er Sprin	ıg, Marylan	d 20906
The	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 9 200	32. Registrar's Signa	ature &	Spark	2			

State of Maryland / Department of Health and Mental Hygiene 2004 07738

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth 3. Time of Death Month Year **Physician** MATTHERES MANIA 1AM 2004 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES Mariner Health of Greater Laurel Laurel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 577-30-8739 May 11,1914 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at 1 tyes 2 □ No Director Pr. Geo. Beltsville MD 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 6128 Odell Road 20705 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 ☐ No þ 3℃ Widowed 4 Divorced Completed 15. Decedent's Education
(Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry University of Elementary/Secondary (0-12) College (1-4or 5+) Cook 7th Marvland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lottie Ross John Henry Crump, Sr. ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 6404 Cipriano Rd., Lanham, MD Sheila Gross Simpkins (Cousin) 20b. Place of Disposition (Name of cemetegs cremetory or other place)
MD Nat'l Mem. Park Date 20c. Location - City or Town, State 20a. Method of Disposition ₱₽Burial 2 ☐ Cremation 3 ☐ Removal from State 2/21/04 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) month /Medical Examiner Examiner anding physician and use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760. Physician/Medical that initiated events resulting in death) Last ō Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 Yee 2□ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 ☐ Yes 2 100 1 ☐ Yes 2 ☐ No After this certificate e Hospital or Attending Physicien: 124 hours efter death. e Funerel Director: After this certifica letely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hou To the Funel completely fi 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifie Toward (Hem 23a) (Type Print) 14211 Laurel, MD 20707. 31. Date filed (Month, Day, Year) State FEB 18 Registrar

DHMH 16 Rev 6/95

			For State of N	Maryland / Depa <i>Cer</i>	rtment of Health and tificate of Death	Mental Hygier	ne 2004	07739
	Physicia	เท	Decedent's Name (First, Middle, Last) RAY NORMAN	MILLER	JR.	2. Date of Death Jan. 26	^D 2 ^y OO4 Year 1	3. Time of Death 5:39 M
>	/Medic Examin	_	4a. Facility Name (If not institution, give street and number Univ. of Maryland Med	ical Syst.	4b. City, Town, or Location of Deat Baltimore	h	4c. County of Death	
I	Funeral Director		N/A 1ĂM 2□F	Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min. 1 3	(Month Day Ye	9. Birthp Cour 2004 Maryl	lace (State or Foreign htry) and
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County Manual Land Care Monay Inc.	10c. City, Town or Loc			1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
:	death with the Maryland ms 23a or 28a-f show	Olrecto	Maryland St. Mary's 10e. Street and Number		10f. Zip Code 20619	10g.	Citizen of What Cour	itry?
		Funeral Directo	44788 Locust Ridge Court 1 11. Marital Status 12. Was Deceded Armed Force 1 Yes 2 Hyes, Give	ent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Stress, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
9500-G12	within 72 hours atter ene. than "naturel", or ite he Medical Exunên	Completed by	3 Widowed 4 Divorced Year or Date 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-44)	16a. Deced	lent's Usual Occupation kind of work done during most of wo DO NOT use retired)	nking	o. Kind of Business/In	
N	e filed with al Hygiene other tha vent, the		17. Father's Name (First, Middle, Last)	Inf	ant 18. Mother's Na	me (First, Middle, Maid	Infant den Sumame)	
_	should be tind Mental I	To Be	Ray Norman Miller, Sr.			lia Rae Co		
			19a. Informant's Name/Relationship (Type, Print) Ray Norman Miller, Sr./Fa	11700	ng Address (Street and Number or A Locust Ridge Co		•	2001
Baltimore,	permit. Pages 1 and 2 Department of Health Important: if item 27 i eny injury or othar tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo- cemetery, cren St. Francis	natory or other place) Xavier Cemetery1/30/	'2004 Leo	c. Location - City or To	aryland
Balti	permit. Departir Importa eny inju		21. Signature of Funeral Service Licenses	liner 22	Name and Address of FacilityMat P.O. Box	tingley-Gard: 270 Leonard	iner Funeral town, Maryla	Home, P.A. nd 20650
	Pnysician		23a. Part Enter the disease, or complications that cau shock, or heart failure. List only one cause on each lmmediate Cause (Final disease or condition	used the death. Do not enter the line. Blogy of Ca		c or respiratory arrest,		Approximate Interval Between Onset and Peath 63 Mln
	/Medical Examiner		resulting in death)	as a consequence of):				
760,	ate be executed hysician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or Due to					
68	tificate I ig physi as the t	l edicai	d					
.O. Box	he death certificat the attending phy thed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outco 1 ☐ Live birti 4 ☐ Pregnar 9 ☐ Unknown		23d. Date of deliver Month			
S, D	luires that the de n signed by the a lid be detached t	by	Part II. Other significant conditions contributing to dea	th but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	cco use contribute to t 2 ⊠No 3 □ Prot	he cause of death? pably 4 Dunknown
Vital Record	The law requires that the ate has been signed by the page 2 should be detached.	Completed				24a. Was an autopsy performed	d? death?	psy findings available impletion of cause of
Vita	Physician: The I rthis certificate ha ral director, page	Be	25. Was case referred to medical examiner? ★ Yes 2 No Hospital: 1 🛱 Inp	patient 2 ER/Outpatier		eath <i>(Check only one)</i> Home 5 \(\text{Residence}	e 6 □Other (Speci	
ion of	유유	atlon: To	27 Manner of Death 28a. Date of			28d. Describe how		
Division	i Si te	Certification;		of Injury - At home, farm, sti g, etc. <i>(Specify)</i>	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospital within 24 hours a To the Funerel completely filled	ledical (29a. Certifier (Check only one) 1X Certifying Physician: To the base and manner	sis of examination and/or in	h occurred at the time, date and place exerting the properties of the contract	curred at the time, date	and place, and due t	o the cause(s)
	To th within To th	Ž	29b. Signature and title of certifier 1. May 12. 12. 12. 12. 12. 12. 12. 12. 12. 12.	(m)	29c, License number P 1 7 7 6 6	29d,	, Date signed (Month, Feb. 2, 2)	DÖ'4 ^{rear)}
			30. Name and address of person who completed cause Richard Telesco, MD	of death (Item 23a) (Type, 22 S. Gre	ene St. Baltin	nore, Md	21201	
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 4 2004	gistrar's Signature	beile			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Feb. 17, 2004 Year **Physician** 2:14pm Dorothea /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Montgomery Rockville Collingswood Nursing Home if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 / 21 / 1924 9. Birthplace (State or Foreign Country) Port Huron MI 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Months 364-20-2562 1 □ M 2 X F 80 Director Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryls Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any hurry or other traumatic event, the Medical Examiner must be notified at page. 1 ☐ Yes 2 ☐ No Germantown MD. Montgomery **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 16905 Germantown Road 20874 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2½ No if Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 2 No Specify. Be Completed by 3 2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Mary Cook Henry Ketels 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11906 Leatherbark Way Germantown, MD 20874 Rebecca Brandon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/21/04 Port Huron,MI Woodland Cemetery b 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fun ral Service Livens 22. Name and Address of Facility
PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or head failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the bunel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yus 2 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28b. Time of Injury 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Xcertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifie 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number Feb. 18, 2004 SHAMIM

DHMH 16 Rev 6/95

State

Registra

Dr. Silver SPRIAG, MD

30. Name and address of person who completed ceuse of death (Item 23% (Type, Print)

31. Date filed (Month, Day, Year) FEB 1 8 2004

299

32. Registrar's Signature

OB MANG

		•	For	epartment of Health and M Certificate of Death	Re	g. No. 2004	9 1 1 1
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Paul John Metcalf		2. Date of Death Month Februar	Dey Year y 17, 2004	3. Time of Death 12:26 P M
7	Examin		4a. Fecility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	,	4c. County of Death Montgome:	
	Funeral Director		212-30-0100 91	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Feb. 29,	Year) Cou	* '
	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, the Madical Examiner must be rigitive at	ted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Montgomery Silver 10e. Street and Number 441 Northwest Drive 11. Marital Status 1 Never Married 1 Never Married 3 Widowed 1 Divorced 15. Decedent's Education (Specify only highest grade completed)		ecity Yes or No- Rican, etc.)	USA 14. Race - Ameri Bleck, White, Specify: Whit	can Indian, etc.
0	oe filed within 72 al Hygiene. I other than "nal want, the Wedle	Be Completed	Flementary/Secondary (0-12) College (1-4or 5+)	ilitary Officer	1	United Stat Armed Force Haiden Sumame)	
larylaı	2 should be filed and Mental Hygi Is marked other aumatic event,	To		Mailing Address (Street and Number or Run			
Baltimore, M	permit. Peges 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked. any injury or other traumatic evonce.		20a. Method of Disposition 1 Saburial 2 Cremation 3 Removal from State Cameter Gate 0	Northwest Drive, S Disposition (Name of commatory or other place) of Heaven emetery 200	uary 20 2	Oc. Location - City or To	
Balti	permit. Departm Departm Importal any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collins 500 University Blvd	Funeral	Home Inc.	
760,	Physician /Medical Examiner per principle /Medical Physicien and Physician P	Ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last Urinary Tract Due to (or as a consequence of Due to (or as a consequence	Infection i): Hypertrophy ii):	or respiratory arre	st.	Approximate Interval Between Onset and Death Days Years
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. II yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time ol death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv	ery Day Year
S, D	w requires that the been signed by should be detac	by	Part II. Other significant conditions contributing to death but not resulting in Hypertension, Parkinson's Disease			acco use contribute to t	the cause of death?
Vital Record		Completed			24a. Was an autopsy perform	prior to co led? death?	opsy findings available ompletion of cause of
of	ding Ph h. After th funeral	ation: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation 1 ☒ Natural 1 ☒ Natural 1 ☐ Natural 1 ☐ New Year)	patient 3 DOA Other: 4 Nursing Ho	th (Check only one ome 5 Resider 28d. Describe hor	nce 6 Other (Speci	(fy)
Division	el or Atters s after dez el Director ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fair building, etc. (Specify)	m, street, factory, office	281. Location (Str. City or Town,	eet and Number or Rur , State)	al Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	Vor investigation, in my opinion, death occur	red at the time, da	ite and place, and due t	to the cause(s)
•	10 +1	Σ	29b. Signature and little of certifier MACON MICHAEL SIGNATURE AND MICHAEL SIGNATURE AN	29c. License number D32332		od. Date signed (Month, February 1	
	Sta Regist	ate	30. Name and address of person who completed cause of death (Item 23a) (Suresh K. Gupta M.D. 9801 (31. Date liled (Month, Day, Year) 32. Registrar's Signature FEB 2 0 2004	Type Print) Georgia Avenue, #220 Georgia Avenue	, Silver	Spring, MD	20902

			1 10000	State of Maryla	nd / Dep	artment of	Health an	d Mental Hvo	gieneo o o l	4000000
		•	1 - For State Registrar	Otato of Maryta		rtificate of			Reg. No. 2004	07743
	Physici	an	1. Decedent's Name (First, Middle, Las	-				2. Date of Dea Month	ath Day Year	3. Time of Death
	/Media	al	PEARLIE WILLIAM M			4h City Town	, or Location of D		ry 16, 200	
	Examin	er	4a. Facility Name (If not institution, give 17041 Barn Ridge	1.2			er Spri		Montgom	
	Funeral		5. Social Security Number 6. Se		s. last birthday,		r If Under 24			thplace (State or Foreign
Α,	Director		227-14-8250 Usual Residence of Decedent	AW 201	84 Yrs.			Oct 29	, 1919 Vi	rginia
	ryland how		10a. State 10b. County	10c. C	City, Town or L	ocation				10d. Inside City Limits
	8a-fs	Director	Maryland Montgom	ery S	Silver	Spring 10f. Zip Code			10g. Citizen of What Co	
	with the		10e. Street and Number 17041 Barn Ridge	Da		20906			USA	outrity:
	death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.			? (Specify Yes or No- Puerto Rican, etc.)		
36	s after , or ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give		1 ☐ Yes 2 🛣 N		, , , , , , ,	Specify:	White
8	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show yth, I'ra Medical Evantiner must be rudified at	ted t	15. Decedent's Ed	lucation	16a, Dece	edent's Usual Occ	upation	fartrina	16b. Kind of Business	
215	ithin 7. Ie. Medi	Completed	(Specify only highest gra	College (1-4or 5+)	life.	e kind of work don DO NOT use reti	red)	working	Heating a	
72	Hygier Hygier ther th		17. Father's Name (First, Middle, Last)		S	elf Empl		Name (First, Middle,	Condition Maiden Sumame)	ing
lan	lid be kental ked o ic eve	To Be	James L. Minnick				Lill	ian A. Woo	lfree	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if item 27 is marked other than "natural; or Items 23a or 28a-f show minjoury or other treumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7	Гуре, Print)					or, City or Town, State,	Zip Code)
	1 and Health em 27 ther tr		Herman L. Minnick		Place of Disp	osition (Name of		eltsville,	MD 20705 20c. Location - City or	Town, State
nor	ages ant of l		1 ∑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre	matory or other p		eb 20. 200	·	Spring, MD
Baltimore,	mit. F partme porter y injur		21. Signatu/e o Funeral Service Licen		2	22. Name and Add	fress of Facility	Hines-Rina	ldi Funera	1 Home
<u> </u>	89 = 8		/ Laisn	July						ng, MD 20904
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	olications that caused the de- one cause on each line.	ath. Do not er	nter the mode of d	ying, such as ca	rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Corona Due to (or as a conse		ery Dise	ease			10 yrs
	Examiner		Someonially list conditions	h. Athero	osclero	sis, Ger	neralize	đ		20 yrs
	sit ad	iner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury	Due to [or as a cons-						30 yrs
<u>,</u>	ate be executed nysician and he burial-transit	Examiner	that initiated events resulting in death) Last	c. H per Due to (or as a conse	$ ext{Lipide}$ aquence of):	mia				30 yrs
1760,	ysicia y buri	cai		d						
x 68	ertificat ling phy e as th	Physician/Med	IF FEMALE:	23a If was autooms of prog	ID 2 D CV				00.1 Day 11.1	P
Вох	eath certifi attending I for use as	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3	☐Ectopic pregnar ☐ Other (specify)			23d. Date of de Month	Day Year
Ö.	that the de ed by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						MERCHANIS OF THE
S, P	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the	underlying cause	given in Part I.		obacco use contribute t res 2□No 3ሺP	o the cause of death?
ecords,	requi	eted	Aortic Aneurysm					24a. Was		utopsy findings available
α	The law ate has page 2	Completed	Hypertension					autop	prior to death?	completion of cause of
Vital		BeC	25. Was case referred to medical examiner?					Death (Check only o		7 2 110
of V	this ald di	2	1 Yes 2 No		ER/Outpatie	HIL 3 DOA		-	tence 6 Other (Spe	ocity)
OUO	Affe une	tion	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	V	vork? □Yes 2□No		low injury occurred	
Division of	or Attendate death after death I Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec		treet, factory, offic	e e	28f. Location (S City or Tox	Street and Number or A	ural Route Number,
	urs afte	1								
	To the Hospital or At within 24 hours after of to the Funeral Direct completely filled in by	edical		nysician: To the best of my kininer: On the basis of examination and manner stated.						
	To the l within 2.	Me	29b. Signature and title of certifier	11/10	1	29c. Lice	ense number		29d. Date signed (Mon	
}	5		1	Mille	SON	1 60	11921	/	2-15	104
			30. Name and address of or so who	completed cause of death (It	em 23a) (Type	D. Print)	ars #1	(RD#1-	9 BBT	3. 20FM
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature			1-6 11	11 (974)	7
	Regist	rar	FEB 2 0 201	J4 Dinera	Ø	Spark	21			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician FEB. 14, 3:20 A 2004 MOON WILLIAM ROY SR. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Neme (If not institution, give street and number) **Examiner** PRINCE GEORGES **LANHAM** DOCTORS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Hours Min. 1**X** M 2□ F SEPT. 25,1909 VIRGINIA 94 Director 578-24-3675 Usuel Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County *ohe 28a-f show 1X Yes 2 □ No RIVERDALE PRINCE GEORGES Directo MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or Itams 23a or the Medical Examiner must be: 20737 U.S.A. 5809 RITTENHOUSE ST. death Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 No Specify: Specify: ģ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene TRUCKING TRUCK DRIVER 10 other t 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 shuuru uu. Department of Health and Mental Hy important: If item 27 is marked oth any injury or other traumstic even once. 17. Father's Name (First, Middle, Last) Be RENEE MOON 2 WTT.I.TAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45654 RUTHERFORD BLVD., GREAT MILLS, MD. 20634 JANE ORINO/FRIEND CLARA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-16-2004 RIVERDALE, MD. CHAMBERS CREMATORY 21. Signature of Funeral Service Licinsee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M/Chamber MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 5 YRS. **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): nding physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. seen signe Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2X No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 X No page 1 ☐ Yes 2 ☐ No ospital or Attending Physician: The hours after death. uneral Director; After this certificate the filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1X Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 🔀 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending Injury 1 X Naturai 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitai within 24 hours a To the Funeral I 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannerstated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatuşe

State Registrar 31. Date filed (Month, Day, Year) FEB 1 7 2004

WILLIAM D. ROSSON,

M.D. 5701

32. Registrar's Signature

eted cause of death (Item 23a) (Type, Frint)

85th AVE, NEW CARROLLTON, MD. 20784

D16897

FEB. 14, 2004

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

			For State Registrar	State of Mar		partment of Fertificate of			giene Reg. No. 2004	07746
-			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath Day Year	3. Time of Death
	Physicia		Lillian M. Ma	ackie				Februa		3:30 a M
	/Medic Examin		4a. Fecility Name (If not institution, given	re street and number)		4b. City, Town, o	r Location of Dea	th	4c. County of Deal	th
			Holy Cross Rehab	ilitation &	Nursing Co	r Burton	nsville		Montgo	mery
	Funeral		5. Social Security Number 6.		(In yrs. last birthd	Months Days	If Under 24 Hrs Hours Min		h 9. Birt y, Year) Co	hplece (State or Foreign
	Director		5/9-14-2424	1 U M 2 Z J F	82 Yrs			Aug. 10	, 1921 Was	shington, DC
	pu *	}	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or	Location				10d. Inside City Limits
	aryla shov	5								1 ☐ Yes 2 ☑ No
	he M	ect	Maryland Montgo 10e. Street and Number	mery	Silver	10f. Zip Code			10g. Citizen of What Co	ountry?
	a or	급	912 Annmore Drive				20902		USA	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "heulical Examinar must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent Ev	ver in U.S.	Was Decedent of H If Yes, specify Cub		Specify Yes or No		
10	r iten	F	1 ➡ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No				rto Rican, etc.)		
93	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Sp e спу:		Specify: Whi	te
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. De	cedent's Usual Dccup live kind of work done e. DO NOT use retire	ation during most of we	orking	16b. Kind of Business	
7	thin en.	nple	Elementary/Secondary (0-12)	College (1-4or 5+) Iif				U.S. House	
21	ygien yer th	Cor		1		Secretar		ma /Fimt Afiddle	Representa	itives
p	d oth	Be	17. Father's Name (First, Middle, Las	t)					Maiden Sumame)	
<u>X</u>	Men Merke Marke	2	Robert Mackie					e C. Van	Riswick er, City or Town, State, .	Tin Code)
Maryland	2 sh and ls m		19a. Informant's Name/Relationship							
	l and tealth em 27 ther t		Mary M. Workman	Sister				Date Date	ring, MD 20 20c. Location - City or	
or	yes I to I t		1 ⊠ Burial 2 ☐ Cremation 3			sposition (Name of crematory or other pla	1 - 0 0	ruary 27		
Ë	Parit Parit		*4 □Donation 5 □ Other (Spec		Fort Lin	coln Cemet		2004	Brentwood	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Lice	John	. 5	Francis J. 00 Univers	. Colling	1. W., Si	Home Inc. lver Sprin	
27			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused to y one cause on each line	he death. Do not	enter the mode of dyl	ng, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	_a Congesti	ve Heart	Failure				
No.	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
(C.	LAdilliles	_	Sequentially list conditions,	b. Due to (or as a	consequence of):					
	ed sit	lne	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence on.					
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
760,	ate be executed hysician and the burial-transit	calE								
687	ficate p phys is the	Pa		0.						
Вох	death certifica e attending ph d for use as th	hysician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		205			23d. Date of de	livery
ă	d for	Cla	in the past 12 months? 1 ☐ Yes 2 ☑ No	1☐ Live birth 2 4☐ Pregnant at ti		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	.у		Month	Day Year
0	the ty th	hys	9 Unknown	9∐ Unknown						
٣.	requires that een signed b hould be deta	by P	Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying cause gr	ven in Part I.	23e. Did t	obacco use contribute to	o the cause of death?
rd	w require been sig should b							10	Yes 2⊠No 3∏P	robably 4 Unknown
Records,	aw request been 2 shoul	ompleted						24a. Was auto		utopsy findings available completion of cause of
R	The law ate has b page 2 sl	E						perfo	ormed? death?	_
Vital	(0	Se C	25. Was case referred to medical				26. Place of De	eath (Check only o	one)	
₹	dir dir	To B	examiner? 1 ☐ Yes _2K No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpa	atient 3 DOA	her: 4 X Nursing	Home 5 ☐ Resi	dence 6 Other (Spe	ocify)
n of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim		ry at ork?	28d. Describe	how injury occurred	
Sio	Attending r death. Ctor: After by the fune	atle	2 Accident investigati			M 1]Yes 2□No	-		
Division	or Attendation of the death of Director: /	ertification:	3 ☐ Suicide 6 ☐ Could not determine			, street, factory, office		28f. Location (City or To	Street and Number or R wn, State)	ural Route Number,
	itel o	O		1				1		
	To the Hospitel or within 24 hours after To the Funerel Directory Completely lilled in b	edical	29a. Certifier 1 Certifying F (Check only 2 Medical Expone)	Physician: To the best of aminer: On the basis of aminer states	examination and/	seath occurred at the to or investigation, in my	ime, date and plac opinion, death oc	ce, and due to the curred at the time,	date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mainer stat	0 0.	29c. Licen	se number		29d. Date signed (Mon.	th, Day, Year)
				edma	w m	10 Da	7001			
	3		30. Name and address of person wh	o completed cause of de	ath (Item 23a) (To		7801		February	26. 2004.
			Aimee J. Seidma			rnestown R	d. N. F	otomac	MD 20878	
	St	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature			J. Comac.	20076	
1	Regist		FEB 272	004 Janes	0	spark	2/			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2011 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dey 2-23-04 2:50 P.M. Robert T. Mangum 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Name (If not institution, give street end number) Manor Care Nursing Home Potomac Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1⊠ M 2□ F Yrs 217-28-8727 71 MD 4-10-32 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Montgomery <u>Burtonsville</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 3838 Bell Rd. 20866 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 log Yes 2 □ No 153-55 If Yes, Give Year or Dates: 1 ☐ Never Married 2 1 Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Self-employed Florist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Lest) Grafton F. Mangum Rose E. Eckloff 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3838 Bell Rd. Burtonsville, MD 20866 Louise C. Mangum - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 2-27-04 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi F. H. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that haved the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung cancer Due to (or as e consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

δ

Completed

Be

Funeral

Director

Peges 1 and 2 should be filed within 72 hours efter death with the Marylend

Baltimore, Maryland 21215-0020

lem 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Modical Examinar must be notified at

Depertment of Health and Mental Hygiene. Important: if Item 271s marked other than any injury or other treumatic event, the Monte.

edical Examiner or Attending Physician: The lew requires that the death certificate be executed attending physician end for use es the buriel-trans within 24 hours efter death.

To the Funeral Director: A

Sompletely filled in by the fu

Division of Vital Records, P.O. Box 68760,

Part II. Other significent conditions co	ntributing to death but not res	sulting in the underlyin	g caus	e given in Part 1.		23b. Did tobacco use co 1 ☐ Yes 2⊠ No	ntribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
						24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
						1 ¥ Yes 2□No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Other		Check only one) 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Manner of Deeth 1 ☑ Netural 5 ☐ Pending 2 ☐ Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury M		Injury at Work? 1 ☐ Yes 2 ☐ No	280	d. Describe how injury occur	red
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fac fy)	tory, of	fice	28f	. Location (Street and Numb City or Town, State)	ber or Rural Route Number,
29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deeth occurr ation end/or investigat	red et th	ne time, date end plac my opinion, death occ	e, and	d due to the cause(s) and ma at the time, date and place,	anner as stated. and due to the cause(s)
29b. Signature and title of certifier	٨		29c Li	cense number		29d. Date signe	d (Month, Day, Yeer)

State Registrar 31. Date filed (Month, Day, Year) FEB 27

32. Pegistrar's Signeture

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Anush Dadgar, M. D. 13219 Executive Park Terr. Germantown, MD 20874

H0051280

2-24-2004

To the Hospital within 24 hours e To the Funeral E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 07748 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 18, 2004 **Physician** 12:30A M FREY MANTEL HELEN /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sunrise Assisted Living Rockville Montgomery If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country)
 New Jersey 8. Date of Birth (Month, Day, Year)
Dec 24, 1919 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖔 F 84 Director 138-16-4558 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-1 ahow other traumatic event, it a Mudicial Examinar must be routified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 USA 12405 Braxfield Ct, #16 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 ☐Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Researcher Science 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be f Department of Health and Mental P Important: If item 27 is marked of Julia Hochstuhl 0 Albin Frey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12405 Braxfield Ct, #16, Rockville, MD 20852 Julie H. Phillips/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition any injury or o 1 Burial 2X Cremation 3 Removal from State Fort Lincoln Crematory Feb 21, 2004 Brentwood, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dis shock, or he ure Immediate Cause (Final Physician Multi-infarct Dementia disease or condition resulting in death) 5 Years /Medical Due to (or as a consequence of) Examiner 5 Years Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 21 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 2 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 DOther (Specify) 15 TO the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending PI within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 20, 2004 D-05120 un den mus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Emmer, MD., 6316 Democracy Blvd., Bethesda, Maryland 20817 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State FEB 23 2004 Registrar

		-	For State Registrar	State of Maryland	Depa Cer	artment of H	ealth and M Death		ene 2004	07749
			1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Orea France	s Marshall				reb.	20,2004	7:45p M
ř.	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			Prince George			Chever1	y If Under 24 Hrs.	O Date of Birth	Prince G	
Н	Funeral Director	- 1	5. Social Security Number 6. Sec. 77 - 03 - 0713A	7. Age (In yrs. last	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry) hington, D(
	ס	L	Usual Residence of Decedent							10d. Inside City Limits
	show		10a. State 10b. County D C None	10c. City, T Wash						1X□X/es 2 □ No
	8e-f	cto		Wash				100	. Citizen of What Cor	
	with ti	2	10e. Street and Number 5000 Nannie He	len Burroughs	Av	10f. Zip Code 2 0 0 1 9)		.S.A.	array.
	s 23	eral	11. Marital Status	12. Was Decedent Ever in U.S.		Was Decedent of Hi			14. Race - Amer	ican Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Items 23a or 28e-f show event, the Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		fYes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto	Rican, etc.)	Specify: B]	
21215-0036	2 hou		15. Decedent's Ed		6a. Dece	dent's Usual Occupa	ation		Bb. Kind of Business/I	ndustry
215	within 73 ene. then "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)		DO NOT use retired		li ig		
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Jor	of E ages		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State -+		natory or other place ncoln Ce		704 B	rentwood	. hM
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Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.	N N	X uson IV h	art 064						D.C.20011
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8760,	The law requires that the death certificate be executed to the last been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequent Due to (or as a consequent d.	Ge of):	CARDU	Discu	CAJE LAR J	DILAN J	6
O. Box 6	it the death certifica by the attending pt tached for use as t	Physician/Medical	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MENO 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deatt 9 □ Unknown	ath 3	Ectopic pregnancy Other (specify)	,		23d. Date of deli Month	very Day Year
٩	uires that the signed by Id be detac	by	Part II. Other significant conditions o	ontributing to death but not resulting	ng in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	
Records,	The law requii ate has been s page 2 should	Completed			<u>.</u>			24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
Vital		a)	25. Was case referred to medical				26. Place of Dea	th (Check only one		
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on of	Jing Afte fune		27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Bb. Time o Injury	Worl	yat k? Yes 2 □No	28d. Describe how	vinjury occurred	
Division	= = = =	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, st	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C		ysicien: To the best of my knowle niner: On the basis of examination and manner stated.						
	Cother vithin complex	Me	29b. Signature and title of certifier	21		29c. Licens	e number	29	d. Date signed (Monti	h, Day, Year)
	- 5 - 0		> Mull			DZ	7577	0-2	2/22/	04
	4		30. Name and address of person who Dr. Ophnell Cu	completed cause of death (Item 2: mberbatch 84	за) (Туре, 16 С	Print)		andover	, Md. 20	785
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 5 20	32. Registrar's Signatur		Sparks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 20, 2004 **Physician** 20:45 Mathes RUTH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1 M 2 F 75 New Jersey 579-46-3834 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r Items 23a or 28a-f ehow dner coast be notified at 1 X Yes 2 □ No Maryland | Prince George's Greenbelt Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20770 United States 18T Ridge Road Funerai Pages 1 and 2 should be fited within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel, or any nigury or other traumatic event, the Modical Exercising. White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Environmentalist State Gov 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace England Warren A. Marrison 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Goulait -Daughter 14102 Oxford Drive Laurel, Maryland 20707 20b. Place of Disposition (Name of cametery crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan Crematory 2/23/2004 Alexandria, Virginia 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. owell 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LSCHEMIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicism: The law requires that the death certificate be executed 5 (-1953)

Due to (or as a consequence of): as the burial-tran and attending physician Division of Vital Records, P.O. Box 68760 FAILING REWAL Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? 1 ☐ Yes 2 🔼 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 17 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death Director; / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide after To the Hospital within 24 hours a To the Funeral I completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tsion Berhane, M.D. 3001 Hospital Drive Cheverly, Maryland 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2004 Registrar

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	State of Maryland / Department of Health and Mental Hygiene 200 l	07
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		-	For State Registrar	State of Maryl			e of Dea			g. No.	9 07731
	Physicia	_	1. Decedent's Name (First, Middle, Last						2. Date of Death Month	Day Yea	3. Time of Death
	/Medic	al -	Harold Hatche 4a. Facility Name (If not institution, give		McCurdy		Town, or Locati		February	18, 2004 4c. County of De	
	Examin	er	Manor Care Chevy			1	vy Chas	Montgome			
	Funeral Director		203-24-1393	x 7. Age (In) XM 2□F 85	yrs. last birthde	Months		der 24 Hrs. rs Min.	8. Date of Birth (Month, Day, June 23,	9. B 1918 F10	irthplace (State or Foreign Country) Prida
	yland	}	Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or	Location					10d. Inside City Limits
	e Mar	ctor	Maryland Montgom	ery (Chevy C						1 X Yes 2 No
	with th	Director	10e. Street and Number 8700 Jones Mill	Road			0815			g. Citizen of What (nited Sta	•
	fler death	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever Anned Forces? 1 X Yes 2 □ No	in U.S. 1				ecify Yes or No- Rican, etc.)	Black, Wi	
Maryland 21215-0036	ours a	ρ	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:	1945	1 🗆 Yes			1		merican
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212	d withing giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		cial W				rince Geo	orge County
nd	be file tal Hyg d othe svant,	Be	17. Father's Name (First, Middle, Last)	1					e (First, Middle, M	laiden Sumame)	
Z	d Meni	은	Charles Moore McC		19h M	ailing Addres			latcher	City or Town, State	Zip Code)
σ Z	nd 2 sh lth and 27 is r r traur		Lisa G. McCurdy		1					gton, D.(
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23e or 28e-f show any injury or other traumatic avent, the Medical Exertities fund he notified at once.		20a. Method of Disposition 1 Burial 2 A Cremation 3 4 Donation 5 Other (Specify	Hemovai from State ,	b. Place of Di cemetery, C Chesape		me of other place) cematory	1		Oc. Location - City ϵ	
Baltii	Departm Departm Importar sny inju		21. Signature of Funeral Service Licen			22. Name a	nd Address of F Georgia	Ave.	Guire Fun N.W., Wa	eral Serv	vice 20012
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<u>α</u>	9 og	by Ph	Part II. Other significant conditions of Parkinson	ontributing to death but no	t resulting in th	e underlying	cause given in F	Part I.			to the cause of death?
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Ö	i Diri	Certification;	4 Homicide determined	building, etc. (S	pecity)				City or Town	State)	
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,	511		Mauan	11 Tul	M	1)	D19609		Fe	bruary 19	9, 2004
			30. Name and address of person who Raman R. Tuli,	M.D. 10810	Darnes	stown]	Road, Ga	ither	sburg, MI	20878	
		(31. Date filed (Month, Day, Year)	32. Registrar's							

			1 - For State Registrar	State of	Maryland / De	epartmer Certifica	nt of H te of L	ealth a Death	and M	ental Hy	giene Reg. No. 2	004	07752
			Decedent's Name (First, Middle, Last	st)						2. Date of D		Voor	3. Time of Death
	Physici /Medio		Thomas Leonar	d McMaho	n					Februa			
1	Examir		4a. Facility Name (If not institution, give		ber)	4b. City	, Town, or	Location of	of Death	h 4c. County of Deeth			
			2297 Stratton				ockvi					ntgome	ry
	Funeral		5. Social Security Number 6. S	ex 7 ⊠M 2□F	'. Age (In yrs. last birtho	Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D	rth ay, Year)	Co	thplece (State or Foreign buntry)
þ.	Director		578-38-9981 Usuel Residence of Decedent		87 Yr					Aug. 6	, 1916	Oh:	io
	land ow		10a. State 10b. County		10c. City, Town of	r Location							10d. Inside City Limits
	Many Feb	ţ	Maryland Montgo	merv	Rockv	ille							1 ☐ Yes 2 🖾 No
	r 288	Director	10e. Street and Number				Code				10g. Citizen	of What Co	puntry?
	th wit		2297 Stratton D	rive			2085	54				USA	
	dea erm	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S.	13. Was Dece	dent of Hi	spanic Ori	gin? (Spe	cify Yes or N	D- 14.	Race - Ame Black, White	nican Indian,
36	or it	J.	1 Never Married 2 Married	1⊠Yes 2 If Yes Give	No	1 Yes					1	ecity: Whi	
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Maryland 21215-0036	lenta rked ricev	To B	Charles James M	cMahon				E11:	zabei	h Mary	/ Crim	nons	
ary	should have	[T	19a. Informant's Name/Relationship (1	Type, Print)	19b. N	lailing Address	(Street a						Zip Code)
Σ	and 2 naith a n 27 i		Patricia A. McMah	on/ Daug	ghter 229	7 Stra	tton	Driv	e, Ro	ckvil]	le, MD	20854	
ore	es 1 and 2 should be filed of Health and Mental Hygies of Health and Z7 ie marked other ir other treumatic event,	1 8	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from St	20b. Place of D cemetery,	isposition (Nai	me of other place	∍)		ary 27	20c. Locati	ion - City or	Town, State
Ĕ	Pag ment ment ury		`4 □Donation 5 □ Other (Specify		Gate	Heave	n		200		Silver	Spri	ng, Maryland
Baltimore,	permit. Pages 1 Department of H Important; if Ite any injury or of once.		21. Signature of Funeral, Service Licen	see /		Franci		s of Facility	ins I	[unera]	Home	Inc.	
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	/Medical Examiner		resulting in death)		r as a consequence of):		1						
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Вох	andin use	M/I	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy	۵.					23d.	Date of deli-	very
	0 0	sicia	in the past 12 months? 1 Yes 2 No	4 Pregnar	th 2 Fetal death nt at time of death	3 ☐ Ectopic po 5 ☐ Other (sp						Month	Day Year
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isi	Attending Physicien: If death. ector: After this certification in the funeral director.	licat	2 Accident investigation 3 Suicide 6 Could not be		f Injury - At home, farm,			es 2 N		Rf Location (Street and Ni	imher or Ru	ral Route Number,
Division	after Dire	Certification:	4 Homicide determined	building	, etc. (Specify)	Stroot, actory	, onice		-	City or To		mile or man	ar ribute (vuriber,
	spite		29a. Certifier 1X Certifying Phy	/sician: To the b	est of my knowledge, d	eath occurred	at the time	e. date and	d blace, a	nd due to the	cause(s) and	manner as	stated
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th recompletely filled in by the funeral	Me	29b. Signature and title of certifier	20 1	14 5		. License				29d. Date sig		
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			Michael A. 1				Bet	hesd	a, 1	laryla	nd 2	0817	
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State of Maryland / Department of Health and Mental Hygiene 2001

				,	Certi	ficate of	Death		Reg. No.	104	0//5
	Physic	ian	Decedent's Name (First, Middle, La					2. Date of De Month	eath Day	Year	3. Time of Death
	/Med		NORMAND SWAI					Februa		2004	9:40 P.M
	Exami	ner	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or I	ocation of Deat	4c. County	y of Death	
			Manor Care Nurs	ing Home			Silver S	pring	Mont	gomery	r
	Funeral،		5. Social Security Number 6. S	EN OUT	Α,	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th v. Year)	9. Birthpla	ice (State or Foreign
	Director		3/0-20-/933	M 2□ F 81	Yrs.			July 2	0, 1922	New Y	
	pue ≱		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Locat	ion		-			
	sho	7								100	d. Inside City Limits 1 ☐ Yes 2X No
	the A	Director	Maryland Prince (eorge's Bel	tsville						
	with De of		10e. Street and Number			10f. Zip Code			10g. Citizen of	What Countr	y?
	s 236	ra	13219 Greenmount			2070			U.S.A		
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces? 194		s Decedent of I es, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rad Bla	e - Americar ck, White, et	
Baltimore, Maryland 21215-0020	be filed within 72 hours after death with the Maryland ntal Hygiene. Id other then "netural; or Items 23e or 28a-f show event, the Mayleal Examiner must be notified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Div <i>o</i> rced	1 ⊠ Yes 2 □ No €0 If Yes, Give Year or Dates: 194.	10	Yes 2⊠No				y: White	
5-	72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deceden	t's Usual Occup	pation during most of work	ina	16b. Kind of B	usiness/Indu	stry
2	rithin De.	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retire	during most of work Traffic	/			
3	ed w ygier t	Ö		2 Years	Pla	nt Engi	neer		Telec	ommun	ication
n	be fill doth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Surnan	10)	
Ş	Men Men Brke atic	ို	Simone Minneci				Gertrud	- 2			
Ja	d 2 should be filed within th and Mental Hygiene. 7 Is marked other then "reumatic event, the Max		19a. Informant's Name/Relationship (t and Number or Rui				
~	and ealth n 27		Stephen T. Minni				rive, Ell	icott C	ity, Ma	ryland	1 21043
ore	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tre		20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐	20.4	ice of Disposition	on (Name of ory or other pla	ce)	Date	20c. Location -	City or Town	n, State
<u>Ē</u> .	Pag ment		4 □ Donation 5 □ Other (Specify		klawn M	emorial	Park	23/01	Rockvil	le, Ma	aryland
at	permit. Depart Importu any inj		21. Signature of Funeral Service Licen	see	22. N	ame and Addre	ess of Facility LDI FUNER	AT HOME	TNG		2000/
Ш	89 = 29		Nancy A	Verce to	118	OO New	Hampshire	AL HUME	, INC.	r Spri	20904
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused the death.							pproximate
	Physician			one cause on each line.						i In	iterval Between Inset and Death
7	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Aspiration Pr	neumonia	a				1	
		_	roodking in doutin	•	as e consequen					1	
	ed sit	je		_{b.} Hypertension						į	
	ecut end I-trar	Examiner	Sequentially list conditions,	Due to (or a	as a consequen	ce of):					
9	be ey ician buria	ai E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events	Contracture C	of All 1	Extremi	tes				
68760,	v requires that the death certificete be executed been signed by the ettending physician end should be detached for use as the burial-transit	edicai	thet initiated events resulting in death) Last	Due to (or a	s a consequen	ce of):					
×	ding se as	2		Dementia						Í	
Bo	requires that the death c een signed by the ettend hould be detached for us	Physiclan								1	
o	the check	ysic	Part II. Other significent conditions co	ntributing to death but not resulti	ing in the under	lying cause giv	en in Part I.	23b. Did to	obecco use con	tribute to th	e ceuse of deeth?
P.0	hat thing by Jetac							1 □ Y	es 2□ No	3 🗆 Probab	ly 4⊠ Unknown
ŝ	res t	þ									
Records,	nedu een houk	Completed						24a. Was a perform	n autopsy med?	availal	autopsy findings ble prior to
ec	law lasb	힐								compl of dea	letion <i>o</i> f cause ith?
_	nysicien: The law nis certificete has b I director, page 2 s	5						1 □ Y	es 2⊠No	1 □ Y	es 2□ No
of Vital	Physicien: The this certificete and director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only on	16)		A
=	nysic nis ce I dire	ု	1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3	□ DOA Oth	er: 4 🖾 Nursing Hor	ne 5□Reside	ence 6 □Othe	r (Specify)	
0	neral	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injun Worl	v at		w injury occurre		
Š	Attending I st death. ector: After by the funer	äţ	2 ☐ Accident investigation	, , , , , , , , ,			Yes 2 □ No				
Division	or Attending I efter death. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street,	actory, office	2	8f. Location (St City or Town	reet and Number	r or Rural Ro	oute Number,
	tal or	Ç		Saliding Con (Speary)			ļ.	Only of Town	, State)		
	To the Hospital or Attending Ph within 24 hours effer death. To the Funerel Director: Affer th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exami	sicien: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occ n and/or investi	urred at the tim gation, in my op	ne, date and place, a pinion, death occurre	nd due to the ca	ause(s) and mar ate and place, a	nner as stated	d. cause(s)
	withir To th		29b. Signature and title of certifier	(0	. 10	29c. License	number	2	9d. Date signed	(Month, Day	, Year)
	1		> kulti	Votra 1	4.0	D-20	276	1	February	7 25-	2004
	(e	-	30. Name and address of person who co	ompleted cause of death (Item 23	3a) (Tyne Print					,	
			Kirti Vohra, M.D.	, 7710 Bradley	Blvd.,	Bethe		Land 208	317		
See See	Star Registra		31. Date filed (Month, Day, Year) FEB 2.7 2	32. Registrar's Signature	\$	Spark	2				

State of Maryland / Department of Health and Mental Hygien 2004 N7756 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 21, 2004 2:48 P M Mitchell Gladys Royster /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Casey House Rockv111e Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. Year) | Min. | 4 Pril 18 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔀 F Virginia 87 Yrs 238-20-6728 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location s filed within 72 nous a...
If Hygiene.
Joher than "natural", or itema 23a or 28a-f show
Joher than "natural", or itema 23a or 28a-f show
event, the Medical Examit of must be notified at 1 Tyres 2 □ No Prince George's Hyattsville Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number #702 20781 U.S.A. 5805 42nd Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clerk Drug Store 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill thealth and Mental Hitem 27 is marked oth other traumatic even Mary Connley George H. Royster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
eny injury or other trau 20508-A Shadyside Way, Germantown, MD 20874 Sylvia R. Yost - niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 2-24-2004 Brentwood, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Ser 11800 New Hampshire Av., SIlver Spring, MD 20904 Part 1. Enter the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Lung Cancer year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence off Physician/Medical Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No į 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be ρ 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 3 DOA After this c funeral dire 1 ☐ Yes 2 💢 No 2 ER/Outpatient Certification: To Hospice 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: , Completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ō the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title February 21, 2004 D35635 1> who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 6001 Muncaster Mill Road, Rockville, MD 20855 Joseph Kaplan, M.D. 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State FEB 23 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 07755 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Lewis Monzey 02 2004 22 4pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring
If Under 1 Year | If Under 24 Hrs. | 8 Holy Cross Hospital
5. Social Security Number 6. Sex 7. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1**№**M 2□F 214 51 Yrs. 01/01/1937 8992 Liberia Director 67 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exame activities to infilted an any injury or other traumatic event, the Medical Exame activities to infilted an apprecia Silver Spring Md Montgomery Y⊟Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901 10304 Ridgemoor Drive Liberia Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ∐Yes 2√∏No Yes, Give 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Minister 5th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nigh Monzey Nga Lorway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10304 Ridgemoor Dr Silver Spring, Md 20901 Tim Kwenah Son in law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 3/6/2004 Silver spring, Md 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven 22. Name and Address of Facility Snead Funeral Home & Cremation Service 21. Signature of Funeral Service Licensee ta 5732 Georgia ave Nw washington, DC 20011 23a. Part1. Enter the #sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition Physician <u>Asystol</u>e resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury Die to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2☐No 1 Yes 2 No certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2€ No 2X ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 🔀 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Md50969 02/24/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bulent Zaim M.D. 110 Irving Street NW Washington, Dc 20010 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State FEB 26 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Month 6:15 A M MRYCZKO FEB. 25, 2004 ETHEL **VIRGINIA** /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY 14328 BLACKMON DR. ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 😿 F Yrs. 164-22-2430 Director 78 MAY 21, 1925 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD. MONTGOMERY ROCKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14328 BLACKMON DR. 20853 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 TXYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: ۵ 3 Widowed 4 □ Divorced WWII WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mil. Pages 1 and 2 should be filed within 1 pperforment of Health and Mental Hygiene. prortant: if Item 27 is marked other than "I yn jury oc other traumatic event, tra Mes. C. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM F. SNEE ETHEL MILLER 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYBELLE MRYCZKO/DAUGHTER 14328 BLACKMON DR., ROCKVILLE, MD. 20853 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY | 2-26-2004 RIVERDALE, MD. Departi Imports any of 21. Signature of Funeral Service Jacensee 22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A - Chambruses M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPERTENSIVE HEART DISEASE 1 YR. /Medical Due to (or as a consequence of) **Examiner ESSENTIAL HYPERTENSION** 35 YRS. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760. physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 ☐ Fetal death in the past 12 months? Month Day Year detached for 4□Pregnant at time of death 5 ☐ Other (specify) the Ö 9 Unknown ۵ law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe cate has been sig SEVERE CHRONIC DEPRESSION 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown Completed Was autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Division of Vital 1 Yes 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending Injury 5 Pending s after decreal Director: After 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral E 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier comptetely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) lana at D12121 FEB. 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3929 FARRARA DR., WHEATON, MD. 20906 GEORGE SENGSTACK, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State sacks FEB 26 2004 Registrar

			1 - For State Registrar	State of Maryla		artmen rtificat					ene 2 (004	07	757
	Physici		Decedent's Name (First, Middle, Las MILDRFD	GOOLD	MUMF	ORD				2. Date of Death FEBRUARY		004°	3. Time of 4:00	
	/Medic Examir		4a. Facility Name (If not institution, give BEDFORD COURT			SI	LVER		ING		4c. Count	y of Death	Y	
	Funeral Director		5. Social Security Number 6. Security Number 216 60 2872 Usual Residence of Decedent	7. Age (In yrs	i. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Pay, OCt. 8	1908	9. Birthp Cour I	lace (State o try) I inois	r Foreign
	he Marylan 28a-f show officed at	ector	Md . 10b. County Md . Monto	gomery 10c. C	Silve	r Spr							0d. Inside Cil 1 ☐ Yes	
	with t	I Dir	3700 Internationa	l Drive, #35	52	10f. Zip	Code	2090	16	10	g. Citizen of Unite		•	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than *natural', or Items 23a or 28a-1 show many injury or other traumatic event, it is Medical Erains or final by rivilliad at once.	d by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	Was Decedif Yes, spec			gin? (Spen, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ice - Americ ack, White,	an Indian,	
Maryland 21215-0036	s within 72 h jiene. r than *natu tre Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us ema ke	rk done d se retired,	luring mos	t of worki	ing 1	6b. Kind of E	Business/Ind Home	dustry	
yland ;	ould be fited Mental Hyg warked othe	To Be C	17. Father's Name (First, Middle, Last) John J. Goo					Ida	1	Belle	Gree	n		
Mar	d 2 sh th and th and 7 is m traum		19a. Informant's Name/Relationship (7) Marilyn M. Bourdea							a <i>l Route Number, :</i> Gaither	-		^{Code)} 2088	2
Baltimore,	Pages 1 an nent of Heal nt: If item 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify,	20b. Removal from State	Place of Dispo cemetery, cree beck M	sition (Nan matory or o	ne of ther place	e)		Date 20	Oc. Location	- City or To	wn, State	_
Balti	permit. Departm Importa sny inju		21. Signature of Funeral Service Licens	the state of the s						uneral H aytonsvi				
)	Physician /Medical Examiner	liner	23a. Part1. Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	a. Due to (or as a conse	duence of):	or the mod	e of dying	, such as	cardiac o		101		Approximate Interval Bety Onset and D	ween
8760,	cate be executed oblysician and the burial-transit	dical Examiner		c	quence of):									
.O. Box 6	The law requires that the death certific tie has been signed by the attending pi tage 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □	Ectopic pro					1	ate of delive		'ear
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did toba 1 ☐ Yes			e cause of deably 4 🗆 U	
Vital Record		Completed								24a. Was an autopsy performe	od?	prior to con death?	osy findings a apletion of ca 2 No	available luse of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only one)	>/		SSISTE JVING	D
Division of	ding Phys h. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work		2	ne 5 Resident 28d. Describe how		iei (Specily	1 1 1110	
Divis	tal or Attend rs after death at Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory	, office		- 4	28f. Location (Stre City or Town,		ber or Rurai	Route Numb	Der,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medicel Exami	sician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or inv	vestigation,	in my op	inion, deat	d place, a	ed at the time, date	e and place,	and due to	the cause(s)	
•	J. S.	M	29b. Signature and title of certifier	due	M	C	License	number	0	290	I. Date signe	Month, E	yay, Year)	24
	_		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Туре,	Print)	10	01-	115	Y RD	.01	N.E.	1 M3	>3
*	Sta Registr		31. Date filed (Month, Day, Year) FFR 9 5 201	32. Registrar's Sign	ature 4	Sou	u.K.	d.						

			For State Registrar	State of Ma	ryland	Depa / Depa	artmer rtifica:	nt of H	ealth : Death	and Me	ntal Hyg	iene	200	4 077	758
	Physicia /Medic	al	Decedent's Name (First, Middle, Last Elsie Mae Mock 4a. Facility Name (If not institution, give	st)			-		Location	2.	Date of Deat Month	h Day	-	3. Time of D	eath
7	Examin Funeral	ier	Larkin Chase Nur 5. Social Security Number 6. S	esing Home	(In yrs. las		Bow	ie r 1 Year	If Under		Date of Birth (Month, Day, ec. 2,	Pr	ince G	eorge s	Foreign
	Director		213-38-0224 Usual Residence of Decedent 10a. State 10b. County	□M 2 N F	94 10c. City, 1	Yrs.		Days	110413	D	ec. 2,	190	9 [1]	Linois 10d. Inside City	
the Maryla	28e-f sho	Director	Maryland Prince G	George's	•	Raini	er	p Code			1	0a. Citiz	ten of What C	1 ∑] Yes 2	
th with	23a or		4212 29th Street					0712				U.S			
JOO urs after deal	Department of Health and Mental Hygiene. Importent: If item 23a or 28e-f show Importent: If item 27 is marked other than "natural", or itame 23a or 28e-f show any injury or other traumatic event, the Modical Examiner mast be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 No. If Yes, Give Year or Dates:	ver in U.S. o	1			ispanic Or n, Mexica Specify:	igin? (Specif n, Puerto Ric	y Yes or No- ean, etc.)		4. Race - Ame Black, Whi		
d within 72 hours af	natur dical E	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Deced	dent's Usu kind of w	al Occupa	ation furing mos	st of working			nd of Business	,	L
within	than the Me	отрі	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Teac		ise retired	"				ool Sys	orge's Ct stem	Ly.
yland A	fental Hyg rked other lic event,	To Be C	17. Father's Name (First, Middle, Last) Charles Davis)							First, Middle, M		Sumame)		
Mary d 2 shou	is mai		19a. Informant's Name/Relationship (-						Town, State,		
1 and	Health em 27 ther to		Charles R. Mock -	Son		3516 e of Dispo				BOWle			d 20715 cation - City or		
SAITIMOFE, Dermit. Pages 1 a	ent of nt: if it ry or o		1 N Bunal 2 Cremation 3 N 4 Donation 5 Other (Specif		1	etery, crer View				2/20/2	1			Indiana	
	spartm sporter ny inju		21. Signature of Funeral Service Licer						s of Facili	ity Gaso	ch's Fu			e, P.A.	
n a	0 5 % d		23a. Parti. Enter the disease, or com	au alications that caused	the death								le, Mai	ryland 20	0781
	ysician Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Aspirat Due to (or as a	e. ion P	neumo			g, 3001 a3			,		Interval Betwee Onset and De 1 Day	
#	caminer	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a											
sfou, ate be executed	attending physician and for use as the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequer	nce of):									
.O. BOX 68/ the death certificate	0 0	Physician/Medi	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 19 Unknown	2 Fetal de	eath 3	Ectopic p					2	3d. Date of de Month	livery Day Ye	ar
T tat	signed by the a I be detached f	by Pł	Part II. Other significant conditions of	•		•	nderlying	cause give	en in Part	I	23e. Did tob	acco us	se contribute to	o the cause of dea	ath?
Ord requir	been si should l	eted	Dementia, Cerebro	vascular A	ccide	nt	-					s 2 🔀]No 3∏P	robably 4 Dun	known
I KeC	this certificate has b ral director, page 2 s	Completed									24a. Was autops perform 1 Yes 2	y ned? ! M No	prior to death?	utopsy findings av completion of cau	allable use of
	s certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No	Hospital:	nt 2 🗆 EF	VOutpatier	nt 3□ D	OA Othi	26		5 □ Reside		Other (Spe	ocify)	
C 8	after In ea		27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	v 28	8b. Time of Injury		28c. Injury Work		280	d. Describe ha			0.177	
UIVISION tal or Attending	within 24 hours after death. To the Funerel Director: A completely filled in by the for	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Inju building, etc	ry - At home . (Specify)	e, farm, str	eet, facto	ry, office		28f	Location (St. City or Town	reet and , State)	Number or R	ural Route Numbe	∋ <i>r</i> ,
e Hosp	e Funer letely fill	edical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medicel Exar	nysician: To the best of miner: On the basis of and manner state	examination	edge, deatl n and/or in	h occurred vestigation	at the time n, in my op	ne, date ar pinion, dea	nd place, and ath occurred	I due to the ca at the time, da	use(s) ate and	and manner as place, and due	s stated. to the cause(s)	
To th	To th comp	Me	29b. Signature and title of certifier	101	200	-	29	c. License		111	25	9d. Date	signed (Mont	th, Day, Year)	
1			1 (D)		ر ۱۷ او	-) 6		1)	1) (360		Febr	uary 1	6, 2004	_
-	10/		30. Name and address of berson who Dpinder Singh, MD					, #12	24, B	owie,	Maryla	nd 2	20715		
	Sta Registi		31. Date filed (Month, Day, Year) FFR 1 8 2004	32. Registra	r's Signatur	•									

			State of Maryland / Dep	partment of Health and Mertificate of Death	fental Hyg	_	07759
	Physici /Medi		Decedent's Name (First, Middle, Last) JOHN ARTHUR MORGAN		2. Date of Deat Month Musch	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) 9 Carolina Ave.	4b. City, Town, or Location of Death Earleville		4c. County of Death Cecil	
	Funeral Director		5. Social Security Number 195-14-4153 6. Sex 1	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, June 2.	Year) 9. Birthpl 2 1924 De1	ace (State or Foreign ry) aware
	Maryland f ahow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1 MD Cecil Earlev			10	d. Inside City Limits 1 ☐ Yes 2X No
	with the 3a or 28a-	Funeral Director	10e. Street and Number 9 Carolina Ave.	10f. Zip Code 21919		0g. Citizen of What Count	ry?
36	s within 72 hours after death with the Maryland liene. r than "natural", or Itema 23a or 28a-f ahow the Madical Examinat must be notified at	Ď.		Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto		14. Race - America Black, White, e	
Maryland 21215-0036	within 72 hou ene. then "neture the Wedical E	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) h School Physics	ing	16b. Kind of Business/Ind	r
land 2	should be filed ind Mental Hygi s markad other umatic avant, II	To Be Co	17. Father's Name (First, Middle, Last) William Morgan	18. Mother's Name Mildred	e (First, Middle, A	Maiden Sumame)	2C100T
	1 and 2 sh Health and em 27 is m ther traum		Joan T. Morgan (wife) 9 (20b. Place of Disposition 20b. Place of Disposition	ling Address (Street and Number or Rura Carolina Ave. Ea costlion (Name of ematory or other place)	arlevil		1919
Baltimore,	permit. Pages Department of Important: If it any injury or o		*4 Donation 5 Other (Specify) Kent C	remation 3-9- 22. Name and Address of Facility Galena Funeral I 118 West Cross S		Smyrna, D	
	Physician /Medical		23a. Part 1. Eorer the disease, or complications that caused the death. Do not element of heaft failure. List only one cause on each line. Immediate Cause (Final disease or condition a. ASCVD) resulting in death)	nter the mode of dying, such as cardiac of	or respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed to the sas been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate ause. Fills I hoofing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
.O. Box 68	that the death certific led by the attending p detached for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
Δ.	n requires that I been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		accoluse contribute to the	1.4
Vital Records,		e Completed	25. Was case referred to medical			prior to com death? No 1 \(\sum \text{Yes}\)	sy findings available pletion of cause of
Division of Vil	Phys this at dii	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 2 27. Manner of Death 1	of 28c. Injury at Work? M 1 Yes 2 No	me 5 X Resider 28d. Describe hor 28f. Location (Str	nce 6 Other (Specify) w injury occurred reet and Number or Rural	Route Number,
ā	e Hospital or Attending 24 hours after death. • Funeral Director: Atter etely filled in by the funer	ledical Cert	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only 2 Medicel Examiner: On the basis of examination and/or i	ith occurred at the time, date and place, and procurred at the time, date and place, and place and place, and place are the courrest gation, in my opinion, death occurrence.	City or Town, and due to the ca ed at the time, da	use(s) and manner as sta	ted. he cause(s)
	To the within 2 To the Complet	Med	29b. Signature and title of certifier A Jarkon, MD	29c. License number D 153 14		1 which 9, 2	ay, Year)
	Sta	ite.	30. Name and address of person who completed cause of death (Item 23a) (Type HFark as, M) (Imion for spir) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 - 1/1	קו		
DH	Registi MH 17 Rev 1/2	rar	MAR 1 1 2004 Senier 19 19	books			
			ORIGIN	IAL			

			For State Registrar	State of Mar	yland	•	artment o				Reg	g. No. 20	04	07760
	Physici	an	1. Decedent's Name (First, Middle, Las Marion S.	McIntosh							Date of Death Month ebruary		o 🎖 🗗	3. Time of Death 7:00a. M
JK.	/Medic Examin		4a. Facility Neme (If not institution, give	street and number)	Home		4b. City, Tow Hyatt					4c. County	of Death	
	Funeral Director		120 10 9320	ex □M 2 ¹ F	(In yrs. las	st birthday) Yrs.	If Under 1 Ye Months Da		nder 24 h urs N	Hrs. 8. Min. Ma	Date of Birth (Month, Day, ay 17,	1917		lace (State or Foreign in) ington, DC
	e Maryland Be-f show	Director	Usual Residence of Decedent 10a. State 10b. County DC			Town or Lo	n							0d. Inside City Limits Yes 2 □ No
36	perall. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mentalle Hygiene. Important: If them 27 is marked other then "natural; or items 23s or 28e-f show any injury or other treumatic event, the Medical Exandrar must be notified at once.	by Funeral	10e. Street and Number 4017 20th St., 1 11. Marital Status 1 □ Never Married 2 □ Married 3 XWidowed 4 □ Divorced	VE 12. Was Decedent Ev Armed Forces? 1 □ Yes ②□ No If Yes, Give Year or Dates:			10f. Zip Cod 2001 Was Decedent f Yes, specify C	8 of Hispan Cuban, Me	ic Origin? exican, Pu	? (Specify uerto Rica	i ead U	Blad		es ean Indian, etc.
Maryland 21215-0036	within 72 housne.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 1 2			(Give life. L	dent's Usual Ockind of work do	cupation one during tired)	most of	working	10	School		
land 2	should be filed vind Mental Hygie marked other t	To Be Co	17. Father's Name (First, Middle, Last) Charles A. Shiel						Mother's I		irst, Middle, Ma			
Jary	12 short and N		19a. Informant's Name/Relationship								oute Number, (•		Code)
altimore, I	Pages 1 and nent of Healtt ant: If item 23 ary or other t		Ernest W. McIntos 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		ce of Dispo	ZUTN S sition (Name or natory or other Memoria	f place)		vasn: Date /16/0	411-	Oc. Location -	-	wn, Stete aryland
alt:	Departm Departm Importer any injur		21. Signature of Funeral Service by								T. Rhii . Wasl			
1760,	that the death certificate be executed XX Was a street by the attending physician and detached for use as the burial-transit and the partial stransit and the partial stra	dical Examiner	23a. Part1. Enter the disease, or commondate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.	A1z	heime:								Approximate Interval Between Onset and Death
P.O. Box 68	Physicien: The law requires that the death certifica this certificate has been signed by the attending priral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	☐ Fetal d	eath 3	Ectopic pregna Other (specify					23d. Dat Mo	te of delive	ory Day Year
rds, P.	quires that t en signed by uld be deta	ed by Ph	Pan II. Other significent conditions o			ing in the ur	nderlying cause	given in i	Part I.					e cause of death? ably 4 □Unknown
Division of Vital Records,	:: The law requir icate has been si ; page 2 should I	Completed	Decubiti							-	24a. Was an autopsy performe	ed?	Were autoporior to condeath?	psy findings available inpletion of cause of
Ę.	/sicien s certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No	Hospital: 1 ☐ Inpatient	2 □ EI	R/Outpatien	t 3 DOA	Other			heck only one) 5 ☐ Residen		er (Specifi	1)
ion of	ling Afte	Certification; T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)		8b. Time of Injury	28c. l	njury at Work? 1 🗆 Yes		_	. Describe how			,
Divis	al or Atter after de I Director d in by the	ertific	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At hom (Specity)	ie, farm, str	et, factory, offi	ice		28f.	Location (Stre City or Town,		er or Rura	l Route Number,
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edicai		ysician: To the best of piper: On the basis of e and manner state	xaminatio						at the time, date	e and place, a	and due to	the cause(s)
	Tor with the state of the state	Σ	29b. Signature and title of antiful	appea	2/	Lu		7590			F	. Date signed	y 12	, 2004
			30. Name and address of person who					ssio			115, Wa ding 11			OC 20017 St., NE
A.	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 8 2004	32. Registrar		4	()				-			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dev **Physician** Goldena Marie Mason February 18, 2004
4b. City, Town, or Location of Death 4c. County of Deeth /Medical 6:30 A.M. 4e Fecility Neme (If not institution, give street end number) Examiner Riverdale If Under 24 Hrs. Crescent Cities Center Prince George's 7. Age (In yrs. last birthdey) 92 vrs If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F Months Hours Director 1/20/12 Bladensburg, Md 213-03-9075 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Haatth and Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 23a-f show any injury or other treumatic event, the Medical Examinal must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊈ Yes 2□ No Md. Funeral Director P.G. Riverdale 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4409 East West Hwy. 20781 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married I ☐ Yes 2 ☑ No If Yes, Give 3altimore, Maryland 21215-0020 1 Yes 2K No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 7th Laundress Laundry 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Mason Mabel Idell Culley 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Cleo Brewer/ Cousin 4603 Burlington Rd., Hyattsville, Md. 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1- Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 2/24/04 Landover, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S.Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. rall 20019 Part 1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical 1 week neomonla Examiner Due to (or as a consequence of): Examine 1226936 12hecmen's Attending Physician: The lew requires that the death certificets be executed buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No s been signe þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? cate has page 2 s 2 LING cartificate 1 TYes 1 ☐ Yes 2 ☐ No diractor, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 University Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3D DOA this After this funerel 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending death. 1 □ Yes 2 □ No 2 Accident investigation Director: / within 24 hours eftar der To the Funeral Director completely fillad in by th 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Hamicide ò 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) FEBRUARY 18 2004 DO1852 person who completed cause of death (Item 23a) (Type, Print) 4203 Queens Hury Ad Hyattsville All 2078) Name and address @ VURE MIS 0 31. Dete filed (Month, Day, Yeer) 2. Registrar's Signature State FEB 2 3 2004 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 L Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 21, 2004 **Physician** 10:40 aM Marshall Geraldine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Ft. Washington 7614 Bock Road If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 1, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🖺 F New Jersey 75 Director 151-16-6884 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at 1 √Yes 2 □ No Prince George's Ft. Washington Marvland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 United States 7614 Bock Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medical 12th Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be f Health and Mental Item 27 is marked o Wright Corbett Ruth George 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12800 Jervis St. Clinton, Md. 20735 Michael Aukard / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2/27/04 Mount Olivet Cem. Washington, DC 21. Signature of Funeral Service Licensee Alexander So Fapope Funeral Home hette 5538 Marlboro Pike Forestville, Md. 500 Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or comil lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or pach line. Immediate Cause (Final Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cont Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 2 MO 3 Probably 4 Unknown 1 TYes 24a. Was an Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No autopsy performed? Yes 24 No page 2 1 Yes Physician: in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 1 ☐ Yes 2 📉 No 2 ER/Outpatient 2 3 DOA 4 Nursing Home 5 AResidence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I completely filled 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who impleted cause of diam (It in 23a) (Type, Print) Dr. Reda Girgis, 1830 E. Monument St. Suite 500 Baltimore, Md. 21287 31. Date filed (Month, Day, Year) FEB 2 4 32. Registrar's Signature State 2004 Registrar

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r than "netural", or Items 23a or 28a-f show the Medical Examiner must be notified at

item 27 other tr

Depertment of Importent: If it any Injury or o

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Funerai

Completed by

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Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heelth end Mental Hygiene. ont if item 27 is marked other than "netural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0020

Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed ng physician end es the buriel-tren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia þ Be Completed Malnutrition 25. Was case referred to medical ၉ Certification: er death. rector: A n by the f within 24 hours e To the Funeral C completely filled 29a. Certifier Medical To the within 2 29b. Signature and fitte of certified 29c. License number

						U. I IACO UI DOA	III [CITECK OITY OTTO]	
examiner? 1 ☐ Yes 2 🛣 N	lo	Hospital: 1 ☐ Inpatient		3□	DOA Other:	4 🗓 Nursing H	ome 5 Residence	6 ☐Other (Specify)
 Manner of Death 1 X Natural 2 ☐ Accident 	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes		28d. Describe how inj	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	e 28e. Place of Injury building, etc. (5	At home, farm, stree Specify)	t, fact	ory, office		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number ite)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

February 18, 2004

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3503 Perry Street, Suite B Mt. Rainier, MD Raman R. Tuli, MD

31. Date filed (Month, Day, Year)

FEB 2 5 2004



State Registrar

6

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2004 14:00 M Feb. 23, Mildred Mangham /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3605 Silver Park Drive P.G. Suitland Il Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 ☐ F 64 1939 Director 257-66-1098 16, GA. March Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show evant, the Medical Examiner must be notified at Director P.G. 1 X Yes 2 No Md. Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3605 Silver Park Drive 20746 United States or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 te marked other than "natural; or Item any injury or other traumatic event, the Medical Examina Black, White, etc. ☐Yes 2X No f Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Fed. Government Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Valvert Mangham Nellie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2606 Buckner Lane
Temple Hills, Md.

20b. Place of Disposition (Name of cemetery, crematory or other place) Michael Mims/nephew 20748 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Old Mt. Calvary Cem. 3/1/04 4 ☐ Donation 5 ☐ Other (Specify) Concord, GA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md.2074@ 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TRYIDS resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) o detached 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 1 ☐ Yes 2 No 1 ☐ Yes 21 No 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home SP Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA E Sign 28a. Date of Injury (Month, Day Yeer) funeral 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deatl Punaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicet Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dev. Year) February 27, 2004 M 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4467 Old Branch Ave. #203, Temple Hills, Md. Moti L. Koul, MD. 31. Date liled (Month, Day, Year) 2. Registrar's Signature State FEB 27 2004 Registrar

04 - 1274State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1- State Registrar Unpend Item#23a,27,28a-f,Per ME,C829e7#/iis/Action Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1910 P M FEBRUARY 16, 2004 Raphae1 McIntyre /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 □XM 2 □ F 578-15-0565 23 Director Feb. 13, 1981 Wash. DC Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23s or 28e-1 show eny injury or other traumatic event, the Midical Examinary. 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 □ No District of Columbia Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4233 Blaine St., N.E. #103 20019 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 XNo 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: **Black** þ 3 Widowed 4 Divorced led 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry et Elementary/Secondary (0-12) College (1-4or 5+) 12th Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Garland McIntyre, III Brenda L. Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda L. Norris - Mother 3811 V St., S.E. #102, Wash., DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 2/28/2004 Clinton, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licenspe 4001 Benning Rd., N.E. Wash., DC MAG 20019 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part . Enter the disease, or complications that cause if it shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gunshot wound of head /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior 10 -death? 1/12 Yes performed? Yes 2 No 2 □ No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3X DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1**X** Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending \mathbf{p}^{M} 1 ☐ Yes XX No subject shot self investigation 6:47 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury . At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 - Homicide Apartinent Building 4200 Blk. Blaine St. NE, Washington, DC within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 290. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME FEBRUARY 17, 2004 completed cause of death (tem 23a) (Type, Print) (MM) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

MAR 0 2 2004

32. Registrar's Signature

2. Date of Death February 25, 2004 1635 M

4a. Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Death

4c. County of Deeth Talbot

Funeral Director

Baltimore, Maryland 21215-0036

Physician

Examiner

/Medical

ed by the attending physician and detached for use as the burial-transit

or Attending Physicien: The law requires that the death certificate be executed

this certificate has

. After

death.

To the Hospitel

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Box 68760.

P.O.

Division of Vital Records,

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

Richard

Nimmo,

28a-f show other treumatic event, the Medical Examiner must be notified at Director ō or Items 23a Funerai à "natural", Completed than permit. Pages 1 and 2 should be fited to Department of Health and Mental Hygis Important: If item 27 is marked other 1 any injury or other treumatic event, IL.

Memorial Hospital 7. Age (In yrs. last birthday) 1**x** M 2□ F

Easton If Under 1 Year If Under 24 Hrs. Months Days Hours

8. Date of Birth (Month, Day, Year) 01/04/09 Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes X No

150-05-1867 Usual Residence of Decedent 10a. State

5. Social Security Number

Dorchester

10c. City, Town or Location Hurlock

95

Massachusetts

MD 10e. Street and Number

5316 River Road

10f. Zip Code 21643 10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

College (1-4or 5+)

Farmer/Machinist

Agriculture/ Machine Works

17. Father's Name (First, Middle, Last)

Ε. Phillip Nimmo

Mabel Crowell

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type, Print)

Eleanor F. Nimmo/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5316 River Road, Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify)

Hillcrest Cemetery2/28/04 Federalsburg, MD

21. Signature of Funeral Service Licensee Miller J. Eskew 22. Name and Address of Facility $Framptom\ Funeral\ Home,\ PA$ Federalsburg, MD 21632

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ARTERI CORONARI Due to (or as a consequence of): Atheroscloposi Due to (or as a consequence of)

P TYNSIO Due to or as a consequence of)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Day

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 ₩ 70 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 -NO 26. Place of Death (Check only one)

Easton, 110

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 🗌 Suicide

4 Homicide

1 ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29 Firm ture and title of certifier

29c. License number D0053236 29d. Date signed (Month, Day, Year)

Febuary 26,2004

Luco 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 522 Icilewild Ave

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Helmly R. Bruce 31. Date filed (Month, Day, Year) FEB 2 6 2004 32. Registrar's Signature EB2

En.		1	For State Ragistrar	State of	Marylan		artment			and Me		giene Reg. No.	- 7 11 11 1	+ 0776
Phys /Me Exan	dica		Decedent's Name (First, Middle Phuong a. Facility Name (If not institution,	give street and numi	· oil-	0	Ng U	1	Location o		2. Date of Dea Month Fe D	Day 13	Year 2004 County of Death	3. Time of Death
Funer Directo		- 1	1 NR Johns Ho Social Security Number 214-33-1202	dSex 7 1□M 2∏F	Age (In yrs. 54	last birthday) Yrs.	If Under Months	1 Year Days	If Under:	0.4	8. Date of Birt (Month, Da) September	h y. Year)	9. Birth Cou Vie	place (State or Foreign intry) tnam
death with the Maryland ms 23a or 28a-f show must be notilled at	404		Usual Residence of Decedent 10a. State 10b. County 10aryland Montgo	omery	10c. Cit	y, Town or Lo	ocation ville							10d. Inside City Limits 1 ∑ Yes 2 □ No
h with the 13a or 284 at be not	Choole		Oe. Street and Number 100 King Farm	Blvd., Ap	t. 103		10f. Zip	Code 2085	50			•	tizen of What Cou ted Stat	
- in		Dy ruildi	Marital Status Marriad Status Marriad 2 Marriad 2 Marriad 3 Widowed 4 Divorced	12. Was Deced Armed Ford ed 1 Tyes 2 If Yes, Give Year or Dat	es? No		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto F	city Yes or No- lican, etc.)		14. Race - Amer Black, White Specify: A	
within 72 hours affens. within 72 hours affens. than "natural", or the Medical Exam.			15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-	4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us memak	rk done d se retired,	ation Juring mos	t of workin	g		and of Business/I Wn Home	ndustry
Maryland 21 d 2 should be filed wil th and Mental Hygien t7 is marked other th traumatic avent, Ina	1		17. Father's Name <i>(First, Middl</i> e, Nguu Nguyen							Vo :		Maider	Sumame)	
Maryla id 2 should th and Men 27 is marke traumatic			19a. Informant's Name/Relations! Phuongchi Nguy										or Town, State, Z In, Mary	ip Code) land 20874
Baltimore, Marylar permit. Pages 1 and 2 should b Department of Heath and Menit Important: If item 27 is marked any injury or other traumatic a	io	1	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	3 □Removal from S	20b. F	Place of Disponence of Dispone	Cremato	orium,	Inc.	2004		Bet	ocation · City or T	aryland
Departs Imports	DOC		21. Signature of Funeral Server	ensee	M013	05 Ro	2 Name an bert A 57 Wis	d Addres Pum consi	phrey n Aver	Funer	al Home/ ethesda,	Beth Mary	esda-Chevy 1and 2081	7 Chase, Inc. 4-3501
7,60, lte be executed Examined to special and Property Pr	al er	ii Examiner	23a. Part1. Enter the disease, or shock or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Fue to (c	used the dear ch line. A or as a consecutive as a consecu	quence of):			100				TAGE	Approximate Interval Between Onset and Death YRS
of Vital Records, P.O. Box 6870 Physicien: The law requires that the death certificate it this certificate has been signed by the attending physical director, page 2 should be detached for use as the be		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		rth 2 ☐ Fetant at time of	al death 3	□Ectopic pi						23d. Date of deli	very Day Year
ds, P. irres that t signed by d be detac		2	Part II. Other significant condition	ons contributing to de	ath but not re	sulting in the t	underlying c	ause giv	en in Part	l.	23e. Did t		use contribute to	the cause of death?
Division of Vital Records, to Attending Physicien: The law requires talter death. Physicien: The countries to Director: After this certificate has been signed in by the funeral director, page 2 should be		Completed				.,					24a. Was auto perfo 1 - Yes		prior to death?	topsy findings available completion of cause of
Vita sicien: sicien: sicertific lirector,		o Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital: V	npatient 2]ER/Outpatie	ent 3 DC	Oth	or		Check on o		6 ☐Other (Spec	cify)
fing After		atlon; I	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date of	of Injury h, Day Year)	28b. Time of Injury	of 2	28c. Injur Wor 1 🗀	yat k? Yes 2. □		28d. Describe	how inju	ury occurred	
Divisit To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the		Certification:	3 Suicide 6 Could 4 Homicide determ	286. Place	of Injury - At h	nome, farm, si ify)	treet, factor	y, office		:	281. Location (City or To			iral Route Number,
DİVİ To the Hospitel or At within 24 hours after of To the Eunerel Direct completely filled in by		edical	29a. Certifier 1 Certifyii (Check only one)	ng Physician: To the Examiner: On the ba and mann	isis of examin	owledge, dea ation and/or i	th occurred nvestigation	at the tir , in my o	ne, date a pinion, de	nd place, a ath occurr	and due to the ed at the time,	cause(s date an	s) and manner as nd place, and due	stated. to the cause(s)
		We	29b. Signature and title of certifie	r P					e number	\sim		29d. Da	ate signed (Mont	
3			30. Name and address of person				-	-			ORE	MA	2/16/	87-9106
Rec	Stat gistra		31. Date filed (Month Day, Year, FEB 1 9		egistrar's Sign		Spi	aks	17	U1/1M		1	2120	7-1106

State of Maryland / Department of Health and Mental Hygien 2004 07768 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NALABOFF **Physician** Dorothy February P8, 2004 8:10 AM /Medical 4a. Fecility Name (If not institution, give street and number) Shady Grove Adventist Hospital 4b. City, Town, or Location of Death Examiner Montgomery Rockville 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 112-09-4996 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1□M 2**ॉ**F 94 Director New York 12, 1909 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23e or 28e-f show may injury or other traumatic event, the Marical Examinator must be notified at once. 10d. Inside City Limits North Potomac MD Montgomery Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13540 Bonnie Dale Drive U.S.A. 20878 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ð Specify: White 3

Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kanarick Elizabeth Prival Hyman Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zia Codes 14236 Masterpiece Lane, N. Potomac, MD 20878 19a. Informant's Name/Relationship (Type, Print) Nalaboff / son Lloyd 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Beth David Cemetery | Feb. 20, 2004 Elmont, NY 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Full ral service Deense rorchinsky Hebrew Funeral Home, Inc. Mugue 254 Carroll St., NW Washington, DC 20012 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Due to (or as a consequence of): resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical u e as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 70 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? After t Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 4 hours after death Funeral Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29b. Signature and title certifies 29c. License number 29d. Date signed (Month, Day, Year) February 18,2004 D56652 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive, Rockyille MD Pofferiata 9901 MO 31. Date filed (Month, Day, Year) FEB 23 32. Registrar's Signature State 2004 enera Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20, 2004 February **Physician** 5:30A Naveda Victoria Raque1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12400 Vinton Terrace Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jan. 22, 9. Birthplace (State or Foreign County) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Min. 1 ☐ M 2 🗓 F 73 577-58-18888 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene the feath and Mental Hygiene than "natural", or flems 23a or 28a-f show ofter traumatic event, the Madical Examiner must be notified at other traumatic event, the Madical Examiner must be notified at 28a-f show Silver Spring Maryland Montgomery 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 United States 12400 Vinton Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Peruvian White 1 X Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Unknown) (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12400 Vinton Terr., Silver Spring, Md. 20906 Naveda (Husband) Cesar 20b. Place of Disposition (Name of cemetery, crematory or other place) February 25 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages
Department of
Important: If it
sny injury or o 1 Burial 2 XCremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee Rapp Funeral and Cremation Services 23a. Part1. Ehter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, Md. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Creutzfeld-Jacob Disease **Physician** /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Year Day 4 Pregnant at time of death 5 Other (specify) pec the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by pe (Interstitial Lung Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy has certificate 1 Yes 2 🔀 No Physician: within 24 hours after death.

To the Funeral Director: Alter this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death or Attending 1 X Natural 5 Pending 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide To the Hospital 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies D0057304 3 ,0011 Ubroa at Le, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irene Koroulakis, M.D.; 10810 Connecticut Ave., Kensington, Md. 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 26 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O.

04-07770 Jarry D. Norman

VOID

CERTIFICATE #

2004-07770

SEE

CERTIFICATE #

2003-44482

State of Maryland / Department of Health and Mental Hygiene State AMEND ITEM #5 PER FH G829 3/17/04 JICertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Norwood В. Mary February 14, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Capital Heights Prince George's 505 Suffolk Avenue Apt. #407 | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | (Month Days Year) | 1929 5. 239ai 640rity 44664 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2√2F North Carolina 239 16 8401 74 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Yes 2 No Directo Maryland Prince George's Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20743 U.S.A. 505 Suffolk Avenue Apt. #407 or Itams 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 XWidowed 4 □ Divorced Year or Dates: "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12 12th grade College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If item 27 le marked other that any injury or other traumatic event, Inc. 2006. Self-EMployed <u>Restaurant Worker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Scott Christine Farrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig Code) 11517 Georgetown Road Mechanicsville, Virginia 23116 19a. Informant's Name/Relationship (Type, Print) Mr. Larry Farrington (Cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 2/18/04 Beltsville, Maryland Chesapeake Crematory 21 Signature of Funeral Service Licensee 22. Name and Address of Facility ROLLINS FUNERAL HOME, INC. 4339 HINT PL. N.E. WASHINGTON, D.C. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MALIGNANT /Medical Due to (or as a consequence of): Examiner 6 TAS 14 TIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the buriat-transit HYPOXIA and Division of Vital Records, P.O. Box 68760, physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No us certificate has been si director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in 29a. Certifier 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner]stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACHUFUSI NDUBUISI 5000 NANNIE H. EURROUGHS AV. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 2 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene

				State of Mary	•		of Death	R	eg. No. 2 (104	07775
	Physici		1. Decedent's Name (First, Middle, Lest)					2. Date of Dee	th		3. Time of Death
-	Physicia /Medic		Faye L. Ord					Februar	7	2004	1224
)	Examin	er	4a Fecility Name (If not institution, give	street end number)			-	Location of Deeth	4c. County		
			62 Greene Ave.	7 4 4-	and the state of the state of	If Under 1	Aberde	en S C Data of Birth	Hai	rford	
	Funeral Director		5. Social Security Number 6. Security Number 227–16–7851	7. Age (III)	yrs. lest birthday) Yrs.	Months			^{Year)} 1920	Virgi	ace (State or Foreign try) Lnia
	land		10a. Stete 10b. County	10c	. City, Town or Lo	cation				10	Od. Inside City Limits
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	r 28a	5	10e. Street end Number			10f. Zip (Code	1	0g. Citizen of	What Count	try?
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20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martlat Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:			ent of Hispanic Origin? (fy Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)		ce · America ck, White, e	etc.
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Maryland	ind 2 sho alth and 27 is m or traum		19a. Informant's Name/Relationship (Ty) William G. Ord				(Street and Number or F rndale Rd.,			State, Zip (21001	Code)
Baltimore,	Pages 1 a nent of He int: If Item iry or othe		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		b. Place of Dispo cemetery, cren Harford			Date 2/26/04	20c. Location - Aberde	-	
Balti	permit. Departminporta any inju		21. Signature of Funeral Service License	neral Hom			1 3300				
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	v requires that tha death cer been signed by the attandin should be detached for use	by Physician/M	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	nderlying car	use given in Part I.	23b. Did to	bacco use co	ntribute to	the cause of death?
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Ö	after after Direction by	eri	4 ☐ Homicide	building, etc. (Sp	ecify)	,		City or Town	, State)		
_	To the Hospital or Attanding Physician: The is within 24 hours after death. To the Funeral Director: After this certificata ha completely filled in by the funeral director, page:	edical C		iclan: To the best of my ler: On the basis of exam and manner stated.							
	o the	Me	29b. Signature and title of certifier			29c.	License number	2	9d. Date signe	d (Month, E	Jay, Year)
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DHMH 16 Rev 6/95

		4	1 - For State Registrar	State of Marylan	nd / Department <i>Certificate</i>			iene g. No. 2004	07773
2	Physicia /Medic Examin	an al	1 Decedent's Name (First, Middle, Last ATHERIN 4a. Facility Name (If not institution, give	E OL	DEN	own, or Location of Death	2. Date of Death Month		3. Time of Death
K	Funeral Director		579-12-6178	E'S HOSP (x 7. Age (in yrs. 83	Months	HEVERI Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, July 15,	PRINCE 9. Birthpp Year) 9. Birthpp Coun 1920 Washi	GEORGES lece (State or Foreign try) ington, DC
	the Maryland 28a-1 show	Jo.	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G 10e. Street and Number		everly	Code	10	100 Og. Citizen of What Coun	0d. Inside City Limits 1 ☐ Yes 2 X No
36	be filed within 72 hours after death with the Maryland ital Hygiene. do other then "natural", or items 23a or 28a-f ehow event, the Medical Examinat must be notified at	by Funeral Di	5707 Euclid Stre 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	et 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	I.S. 13. Was Decede	785 ent of Hispanic Origin? (Sp fly Cuban, Mexican, Puerto ⊠ No Specify:		United State 14. Race - Americ Black, White, Specify: Whi	ean Indian, etc.
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Maryland 2	S should be filed within and Mental Hygiene. Is marked other then aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) Daniel B. Murph 19a. Informant's Name/Relationship (7		19b. Mailing Address		e (First, Middle, N Catherin ral Route Number,	ne Funk	Code)
	is 1 and 2 soft Health ar item 27 is other trau		Bonnie Jean Trader 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆	Daughter 20b. F	Place of Disposition (Namcemetery, crematory or off. Francis Xavie	ther place)	Date 2	own, MD 2065 20c. Location - City or To Compton, Ma	own, State
Baltimore,	permit. Page Department of Importent: If any inlury or		21. Signarde of Funeral Service Licens	Jadener)	P.O. B	d Address of Facility ngley-Gardiner I Box 270, Leonard	Funeral Hom Itown, MD 2	ne, P.A.	Approximate
	Physician /Medical Examiner		23a. Part 1. Enter the disease or compands, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a		C A M			Interval Between Onset and Death
,092	death certificate be executed e attending physician and id for use as the burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consect d					
.O. Box 68	ires that the death certificat signed by the attending phy d be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	23c. If yes, outcome of pregn 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fetz} \) 4 \(\subseteq \text{Pregnant at time of c} \) 9 \(\subseteq \text{Unknown} \)	al death 3 ☐ Ectopic pre			23d. Date of delive Month	ery Day Year
Δ.	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying ca	ause given in Part I.		pacco use contribute to the	
al Records,	The ate h page	Completed	25. Was case referred to medical			26 Pleas at Don	24a. Was an autops perform 1 Yes 2	prior to condeath? No 1 Yes	psy findings available impletion of cause of 2 No
of Vital	ding Physician: h, After this certific funeral director,	: To Be	examiner? 1 X Yes 2 \(\subseteq \text{No} \) 27. Manner of Death		ER/Outpatient 3 DO	Other	ome 5 Reside	ence 6 Other (Specification occurred)	y)
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		M nome, farm, street, factory	1 ☐ Yes 2 ☐ No	28f. Location (St. City or Town	reet and Number or Rura n, State)	ıl Route Number,
	Hospitel 24 hours a Funerel I	edical Ce	29a. Certifier 1 Certifying Ph	ysicien: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, death occurred a lation and/or investigation,	at the time, date and place in my opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as s ate and place, and due to	tated. o the cause(s)
N	To the within ?	Med	29b. Signature and little of certifier	N	290	. License number	36	9d. Date signed (Month,	Day, Year)
de la companya della companya della companya de la companya della			30. Name and address of person who	completed cause of death (Ite	om 23a) (Type, Print)	VERLY M	PARYI A	ND 207	85
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature Speck	,	(1) L-6/2		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** P^{M} FEBRUARY 2.1 0004 3:10 EVELYN RUTH ORDMAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner MONTGOMERY BETHESDA MAPLEWOOD PARK PLACE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/30/1914 Birthplece (State or Foreign Country)
 MASSACHUSETTS 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** Min. Months Hours 1 □ M 2 1 F 90 Director 030-01-0858 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar nent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or items 23a or 28a-f show yor other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director MARYLAND MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9707 OLD GEORGETOWN ROAD #2505 20814 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION 4 THEATRICAL EDUCATOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SPEAR ELIZABETH SISSON ဂ္ ABRAHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MEMPHIS TN 38122 EDWARD ORDMAN/SON 4045 GRAHAM OAKS CT. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 02/24/2004 FALLS CHURCH VIRGINIA NATIONAL CREMATORY * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
DANZANSKY: GOLDBERG MEMORIAL CHAPELS INC
1170 ROCKVILLE PIKE ROCKVILLE MD 2085? 21. Signature of Funeral Service Malluca nanaca 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PULMONARY CARCINOMA /Medical Due to (or as a consequence of) **Examiner** RIGHT UPPER LUNG NEROTIC MASS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year õ in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, sign. Completed by ABDOMINAL DISCOMFORT/NAUSEA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No CHRONIC OBSTRUCTIVE LUNG DISEASE 24a. Was an page 2 certificate 1 ☐ Yes OSTEOPOROSIS 2 🔯 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3□ DOA 2 1 Inpatient funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: After Division To the Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie FEBRUARY 23 2004 D35791 30. Name and address of person who completed cause of death (Item SILVER SPRING, MD 20902 AVENUE MERLYN VEMURY, M.D. 9801 GEORGIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State sepera ouks FEB 2 4 2004 Registrar

Physician //Medical Examiner Vernon A. Offutt, Sr. 4a. Facility Name (If not institution, give street and number) Prince George's Community Hospital Cheverly Funeral Director S. Social Security Number 5. Social Security Number 6. Sex Yrs. Months 10 In Under 1 Year Months Month			1 - For State Registrar	State of Maryland /	Department of I	Health and N Death	Mental Hygie	ne 2004	07775
## Facility Manage (From Facilities) posses interes for Number Prince George's Community Hospital Chewarty Frince George's Community Hospital Chewarty Fr							Month	,	3. Time of Death
Social Security Number Color Name Prince George Security Number Color Name Na					4b. City, Town,	or Location of Death		4c. County of Death	
Symbol State Symbol Sy		Ağı.						Prince	George's
Again to the control of the control			· X	IM 2DE	Months Days				
Vernon A. Offutt, Jr Son 317 Hill Rd., Landover, MD 20785	25 to 28	or		84			June 18,	1919 Wa	sh., DC
Vernon A. Offutt, Jr Son 317 Hill Rd., Landover, MD 20785	yland		10a. State 10b. County	10c. City, To	own or Location			100	d. Inside City Limits
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Vernon A. Offutt, Jr Son 317 Hill Rd., Landover, MD 20785	s 232	a	317 Hill Road	12 Was Decedent Ever in II S	13 Was Decedent of		pocify Vas or No.		
Vernon A. Offutt, Jr Son 317 Hill Rd., Landover, MD 20785	fterd	Fu	1 Never Married 2 Married	Armed Forces?			Rican, etc.)		
Vernon A. Offutt, Jr Son 317 Hill Rd., Landover, MD 20785	rei', o	þ	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 📉No	Specify:		Specify: B1.	ack
Vernon A. Offutt, Jr Son 317 Hill Rd., Landover, MD 20785	72 hc natur	etec	15. Decedent's Educ (Specify only highest grade	cation 16 completed)	(Give kind of work done	during most of work	ting 16b	. Kind of Business/Indu	stry
Vernon A. Offutt, Jr Son 317 Hill Rd., Landover, MD 20785	within and the n	ig E	Elementary/Secondary (0-12)	College (1-4or 5+)		,			/>
Vernon A. Offutt, Jr Son 317 Hill Rd., Landover, MD 20785	Hygin Hygin	ပိ	17. Father's Name (First, Middle, Last)		Unliormed				(B.E.P)
Vernon A. Offutt, Jr Son 317 Hill Rd., Landover, MD 20785	lid be lental ked cov	o.	James E. Offuti	t			Sophie Br	ent	
A Consistion Specify Maryland National Memi 2/20/2004 Laurel, MD	s mar	-	19a. Informant's Name/Relationship (Type				al Route Number, Ci		ode)
A Consistion Specify Maryland National Memi 2/20/2004 Laurel, MD	and and and m 27 in 27 in tra		<u> </u>						_
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Physician Medical Examiner Physician Medical Examiner Sequentially list conditions. Sequential	it. Pa rtmen rtant: njury	À							D
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Physician /Medical Examiner Part Commonwealth Cause (Final disease or condition resulting in death) Cause (Final disease) Cause (Final dise	400	18	23a. Part . Inter the disease, or compli	cations that cause the death. D				A	Approximate
Due to (or as a consequence of): Atherosclerotic Heart Disease Sequentially ist conditions, say leaving a seminarist of the past 12 months? Cause (Disease or Injury) Later of the past 12 months? Later of the pas	Physicia	n	Immediate Cause (Final		cardial Infa	rction			
Sequentially lists conditions: Sequentially lists conditions:	/Medic	ai							
The past 12 months? Company Co	Examine		Sequentially list conditions, b			Disease			
Second of the composition of t	led sit	nlne	cause. Enter Underlying Cause (Disease or injury	Due to or as a consequence	se of :				
Second of the composition of t	execut and and al-trar	xan	that initiated events cresulting in death) Last	Due to (or as a consequence	ce of):				
Section Sect	sicient ysicient e buri	cal		J					
Section Sect	rtificat ng phy as th	Jedi	LIE SEMALE.						
Section Sect	Ath ce tendii	an/N	23b. Was decedent pregnant in the past 12 months?		ath 3 Ectopic pregnance	;y			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 17, 200	the all	Sici	1 Yes 2 No		5 Other (specify)			None	ay roar
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 17, 200	that the ed by detac		Part II. Other significant conditions con	stributing to death but not resulting	g in the underlying cause gr	ven in Part I.	23e. Did tobacc	co use contribute to the	cause of death?
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 17, 200	Jing F After funera	lon	1 Natural 5 Pending	(Month, Day Year)			28d. Describe how ii	njury occurred	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 17, 200	Atten deatl octor:	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home,		,,,,,	28f. Location (Street	and Number or Rural F	Route Number,
29a. Certifier (Check only one) 29a. Certifier (29b. Signature and title of certifier) 29b. Signature and title of certifier (29b. Signature and title of certifier) 29c. License number (29d. Date signed (Month, Day, Year)) February 17, 200	s after	Certi	4 Homicide	building, etc. (Specify)			City or Town, St	ate)	
February 17, 200	Hospit 24 hour Funere tely fills	ical	29a. Certifier 1X Certifying Phys	nar: On the basis of examination	ige, death occurred at the tand/or investigation, in my	ime, date and place, opinion, death occur	and due to the cause red at the time, date	s(s) and manner as state and place, and due to the	ed. he cause(s)
February 17, 200	o the o the omple	₩ Se		and manner stared.	29c. Licen	se number	29d.	Date signed (Month, Da	ay, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	- 3+8		1 / Mathens	Manna. 1.	mo mo	19730		•	
	(15		30. Name and address of person who co	mpleted cause of death (Item 23)	a) (Type, Print)	. 1 12		repruary	1/, 2004
Michael D. Cannaday, M.D. 106 Irving St., N.W. #305, Wash., DC 20010						St., N.W.	#305, Was	sh., DC 20	0010
State Registrar FFB 2 4 2004 Registrar's Signature				Registrar's Signature	book				

State of Maryland / Department of Health and Mental Hygiene 2004 07776 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Karen R. Paige Month 11:30 A M **Physician** February 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges 2512 Ann Arbor Lane Bowie If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 D 46 232-94-8884 March 4, 1957 West Virginia Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Iteme 23s or 28s-f show tre Medical Examiner must be notified at ty∏Yes 2 ☐ No Bowie Maryland Prince Georges Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20716 U.S.A. 2512 Ann Arbor Lane permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or iteme 23a any highry or other traumatic event, the Medical Exportment master once. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give 22 Year or Dates: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Corporation Xerox 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William | Η. Russ Ida Μ. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25401 19a. Informant's Name/Relationship (Type, Print) 92 Evans Run Drive, Martinsburg, West Virginia Trudie Dozier/ Sister 20c. Location - City or Town, Slete Martinsburg, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ⁴ 4 □ Donation 5 □ Other (Specify) 2/26/2004 Rosedale Cemetery West Virginia 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metasta **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner FRSSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetel dea 4 Pregnant at time of death 2 Fetel death 3 Ectopic pregnancy Month Day Year detached for 5 Other (specify) ☐ Yes 2 PNo the 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed Division of Vital Records, 90 2 I No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No has page 2 certificate 1 Yes Physician: director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 27 Mannet of Death Certification: After Injury or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8926 Woodyard DREPNARAYAN IWARR! MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 23 Registrar 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 20, 2004 **Physician** 12:00 P M Booker Purnell Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges 5109 Spring Drive Upper Marlboro | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 24, 1917 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** MM 2 F Marylánd 86 Director 220-03-3890 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at 1 XYes 2 □ No Director Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5109 Spring Drive 20772 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 X Married Specify: Black Maryland 21215-0036 1 Yes 2 No Yes. Give Specify: þ Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than enry injury or other traumatic event, Ins. Andre. Federal Government Janitor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence Purnell Bertie 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Purnell/Wife 5109 Spring Drive Upper Marlboro, Maryland 20772 Elsie Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Cheltenham, 1

Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem; 3/3/04 * 4 ☐ Donation 5 ☐ Other (Specify) Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Funeral Home P.A. Aquasco, Maryland MO1323 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pancreatic Physician cancer 2 months resulting in death) /Medical Due to (or as a consequence of): **Examiner** pertension Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Examiner death certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has ! autopsy performed certificate Division of Vital 1 Yes 2 No 1 Tyes al or Attending Physician: T s after death. Il Director: After this certificate funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0050389 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20777 Marlboro Pike upper Marlboro John H. 14310 012 wills 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State FEB 25 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Gilbert Franklin Paul 2004 eb/vary/6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner General Hospital Vorchester brchoster Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 M 2 □ F Hours July 3, 1930 214-28-2113 73 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or Items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No MD Dorchester Cambridge Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 2359 Jenkins Creek Road 21613 U.S.A. Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 1950–54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.
Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) printer newspaper 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James S. Paul Margaret E. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is m any injury or other traum once. 2359 Jenkins Creek Rd., Cambridge, MD Joan Paul wife 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 2/19/04 | Cambridge MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Brim K. 700 Locust St., Cambridge, MD Dut 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia **Physician** 15 minutes /Medical Due to (or as a consequence of): Examiner eroscierotic Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No V. Jear page 2 After this certificate 1 ☐ Yes 2X No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Medical Certification: To 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Division or Attanding 5 Pending investigation 1 Natural within 24 hours atter death.

To the Funeral Director: At completely tilled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 50804 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Vea) 200 Agistra 17 State Registrar

			1 - For Registrer	State of N	Maryland		artmen rtificate			and M		iene •g. No. 2 (nnı.	07770
	Physici /Medio		1. Decedent's Name <i>(First, Middle, La</i> Lillian Mar	•	1					F	2. Date of Deat Month ebruary	Day	Year 004	3. Time of Death 4:45 A ^M
	Examir		4a. Fecility Name (If not institution, given 46611 Purce11 Fai		r)			Dray				4c. County St	of Death • Mar	y's
	Funeral Director		216-40-6482	Gex 7. A 1 □ M 2 □XF	Age (In yrs. Ia 95	ast birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birth (Month, Day, January 2	Year)	9. Birthpl Count Mary	
	e Maryland a-f show lifted at	ctor	Usual Residence of Decedent 10a. State Maryland St. Mary	, 's	10c. City	, Town or Lo	Drayo	len					10	0d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28 281 be no	Funeral Director	10e. Street and Number 46611 Purce11 Far	m Lane			10f. Zip		0630		1	0g. Citizen of \ U	What Count SA	try?
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yland 2	should be filed and Mental Hygid markad othar umatic event, II	To Be Co	17. Father's Name (First, Middle, Last George Washington								(First, Middle, M	Maiden Suman		
e, Mar	カモアナ		19a. Informant's Name/Relationship (Shirley Ann Long) 20a. Method of Disposition		20b. Pl	46580	Puro	cell	Farm	Lane	i Route Number e, Drayo ate		2063	0
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68760,	ficate be executed Typhysician and Typ	edical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a consequence as a c	ence of:	onardti er the mod Alv Alv				-	est,	<u>e</u>	Approximate Interval Between Onset and Death
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Division of Vit	ing Phys After this uneral di	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	Hospital: 1 ☐ Inpa 28a. Date of In (Month, D		ER/Outpatien 28b. Time of Injury	-	8c. Injury Work	r: 4 □ Nur at	rsing Hom 2	(Check only one one 5 Reside 8d. Describe ho	nce 6 Oth)
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	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medical	29a. Certifier Check only one) 29b. Signature and title of certifier	nysicien: To the bes	of examinati	viedge, death on and/or inv	estigation,	at the tim in my op . License	inion, deat	d place, a	ed at the time, da	use(s) and ma ate and place, a	and due to	the cause(s)
Le	A D		30. Name and address of person who Patrick J. Jarboe, MD	completed cause of 24035 Three				ood, M	ン <u>の</u> そ の 2063	36		A-10		1
	Sta Registr		31. Date filed (Month. Day You)	2 2004 N	's Signati	ure	Anna	de a						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 21 2004 Physician Month Roland Leroy Purnell February 10:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21731 Garfield Street St. Mary's Great Mills | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct 21 1934 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 № M 2 □ F 69 Director 577-44-8791 Maryland Usual Residence of Decedent and Mantal Hygiene. Is marked other than "natural", or itema 23a or 28a-1 show raumatic event, the Mudical Exteriment most be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Great Mills 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21731 Garfield Street 20634 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. hours after 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) 12th Non Commissioned Officer US Army filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be find Mental H George S. Purnell, Sr. Rosetta Shuebrooks ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an item 27 is 21731 Garfield Street, Great Mills, MD 20634 Ottilie Purnell / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite 1 월 Buriai 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Luke's United Met.02/28/2004 Scotland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 1100052 23a. Part1. Enter the disease, or conficiations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1XYes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier H0055751 6 who completed cause of death (Item 23a) (Type, Print)
-Notch Rd. CALFOYNIA MD 2019 JENNIFER Schmidt D.O. Three Notch 2004 A Samuel 2004 State Registrar

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Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menti Important: If item 27 is marked any injury or other treumatic once.		21. Signature of Funeral Service Licer	Byl		50	00 Un	iver	sity	B1vd	Funera .W., S	ilve			MD 20901
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Usual Recidence of Decedent 10c. City, Town or Location 10c. City To			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland		nent of Heal cate of Dea	ath		ne no. 2001	3. Time of Death	
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23a. Part. Errate he disease, or completations that advect the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Introduction and continues and plants. List only one cause or each line. Introduction the disease or conditions and plants are considered to the cause of death of the continue	Depertme Importent any injury once.			99	22. Nar	ne and Address of F	Facility Josep	h Gawler'	s Sons,	Inc.	
A war a way a war a record of the completion of cause of death? 24. Was a war a way and a war a war and of completion of cause of death? 1 Yes 2 No 1	hysician hysician and hysician	ical Examin	trimediate Cause (Final disease or condition resulting in death) Sequentially list conditions, i. a.y, leading to simple district cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque		a set i	infe	item		Onset and Death	
28. Was case referred to medical examiner? 1 Yes 2 No No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury at Work? 29. Date and Number or Rural Route Number. 29. Cartifier 29. Certifier 29. Date signed (Month, Dey, Year) 29. Date signed (Month, Dey, Year) 29. Date signed (Month, Dey, Year)	ing ruyalcreii. The lay liter this certificate has ineral director, page 2	nysician/Mec	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 Ecto						
26. Place of Death (Check only one) 27. Manner of Death 28. Describe how injury occurred 28. Date of Injury 29. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 28. Date of Injury 29. Date and Number or Rural Route Number. 29. Cartifier 29. Certifier 29. Certifier 29. Date signed (Month, Dey, Year) 29. Date signed (Month, Dey, Year) 29. Date signed (Month, Dey, Year)		by	Part II. Other significant conditions con	. /-	/ - +		Pan I. externai				
29. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. Liquiy at Work? 1 Yes 2 No 28c. Injury at 1 Yes 2 No No Y		0	Myslo dey + 25. Was case referred to medical	not falle	ise. G	tent	CA CAN	autopsy performed?/	prior to c death?	ompletion of cause	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)		2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	DOA Other: 4	ursing Home	5 Residence					
D HPohert Brischhafus DO 4115 Fobruary 11, 200:			ře)								
D HPsheit Brischhafus DO 4115 Fobruary 11,200:	thin 24 ho the Funk impletely f	Medica	(Check only one) 2 Medical Examinate	er: On the basis of examination	rledge, death occu on and/or investig	ation, in my opinion,	, death occurred a	at the time, date an	nd place, and due	to the cause(s)	
	20 20	_	VARabert &		fus	0041	15	Fole	suny	11,200	

		1 - State Registrar			Cer	tificate of	Death		Reg. No	. 200	14 0778
		1. Decedent's Name (First, Middle,	Last)					2. Date of I	Death Da	y Yea	3. Time of Death
Physici /Medio		Helen I	Taye	Potter	•					17, 200	
Examir		4a. Fecility Name (If not institution, s	give street and n	umber)		4b. City, Town,	or Location o			County of De	
		1135 University					Sprin			Montgo	mery
Funeral		Social Security Number	.Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.	last birthday)	Months Day		Min. (Month, I	Day, Year)		irthplace (State or Foreig Country)
Director		230-44-2110 Usual Residence of Decedent		66	YIS.			May 8	, 193	7 V	irginia
and and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation		<u></u>			10d. Inside City Limit
should be filed within 72 hours after death with the Maryland ind Mental Hygiene. The first state 23e or 28e-f show marked other than "natural", or itema 23e or 28e-f show imatic event, it a Medical Evalutest main be invitibed at	ō	W1 1 W			0:1	01					1 ☐ Yes 2 😾 N
28a	Director	Maryland Montg 10e. Street and Number	omery		STIVEL	Spring 10f. Zip Code	,		10g. Cit	izen of What (Country?
3a o		1135 University	Roullerra	rd West	#5 07	209	102		11	SA	
ma 2	Funeral	11. Marital Status	12. Was De	cedent Ever in U.	.S. 13. V	Vas Decedent of	Hispanic Orig	gin? (Specify Yes or I		14. Race - An	nerican Indian,
or Ite		1 Never Married 2 Married	Armed F 1 Tes If Yes, G	2 XNo	1	Yes 2 N		, Puerto Rican, etc.)		Black, Wh	nite, etc.
8 4	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:		Lites ZENIN	з эреспу:			Specify:	hite
disal	Completed	15. Decedent's (Specify only highest)	Education grade completed	1)	16a. Deced	ent's Usual Occi kind of work don OO NOT use retii	upation e during most	of working	16b. K	ind of Busines	s/Industry
	ldu	Elementary/Secondary (0-12)	College	(1-4or 5+)	life. D	OO NOT use retir	ed)	•			
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h and 7 is n Iraun		19a. Informant's Name/Relationship	_	_				r or Rural Route Num		***************************************	and the second second
Health em 27 ther tr		Sherry L. Rhode 20a. Method of Disposition	s Dauş	ghter 20b. P	lace of Dispos	2 Luvie		Potomac,		Land City of	
Department of Health and Menta Important: If Item 27 is marked any njury or other traumatic or		1 Surial 2 ☐ Cremation 3		State Gat	emetery, crem	natory or other pi eaven	ace)	54.0	200. 20	ocation - Oity C	or rown, state
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Depertri	ì	Tucharel IL	1.1.0		Fr	ancis J.	Colli	ns Funeral	l Hom	e, Inc	•
		23a. Part1. Enter the disease, or co	mulications that	caused the death				lvd.,W.,S		Sprin	MD 20901
		shock, or heart failure. List or tmmediate Cause (Final	ly one cause on	each line.	n. Do not onte	ine mode or d	ing, such as	sardiac or respiratory	a11631,		Interval Between Onset and Death
ysician Medical		disease or condition resulting in death)	-	liac Arr	V-						Instant
aminer				o (or as a consequ							5 8 2
	Je .	Sequentially list conditions, if any, leading to immediate		cardial (or as a consequence)		tion					instant
- nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			ŕ						
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physician and the burial-transit	dical		d								
g ph) as th	ed								v I		
attending for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna birth 2 Petal		Ectopic pregnan	01/			23d. Date of d	elivery
ne att	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of de		Other (specify)				Month	Day Year
by the	hys	9 Unknown	9 LJ 011Ki	nown							
igned l	by	Part II. Other significant conditions	s contributing to	death but not rest	ulting in the un	derlying cause g	iven in Part I.				to the cause of death?
should b	ted			·				1	Yes 2	□ No 3 🙀 F	Probably 4 Unknow
2 5	Completed							24a. Wa	s an opsy	24b. Were a	autopsy findings availab completion of cause of
ate ha	Con							per 1 □ Yes	formed?	death?	s 2□No
certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death (Check only			
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fter	on:	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date (Mo:	of Injury nth, Day Year)	28b. Time of Injury	28c. Inj W	ury at ork?	28d. Describe	how injur	y occurred	
death. ctor: A y the fu	Certification:	2 Accident Investigat 3 Suicide 6 Could no	the -	1			Yes 2 N				
after deat Director: in by the	ıtiti	4 Homicide determine	ad 28e. Plac	e of Injury - At ho ding, etc. (Specif)	ome, farm, stre	et, factory, office	•	28f. Location City or T	(Street an own, State	d Number or F	Rural Route Number,
o 24 hours after of Euneral Direct letely filled in by											
Fund Fund tely f	edical	29a. Certifier 1 X Certifying (Check only 2 Medical Ex	aminer: On the	basis of examinal	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and opinion, deat	d place, and due to the hoccurred at the time	e cause(s) e, date and	and manner a f place, and du	as stated. ue to the cause(s)
, a a	Med	29b. Signature and title of Certifler	anu ma	nner stated.		29c. Licer	nse number		29d Dai	te signed (Mor	nth, Day, Year)
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within Comple		80	1 Jes				20511	10	d	-1191	2004
within 2		30. Name and address of person what STEVEN M. SCHWA		()		Print)		JE KENSIN	d	-1/9/	2004

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A THURST	/ Funera	11. Marital Status 1 Never Marrie	ed 2⊡ Marnie	12.	Was Deced Armed Ford	lent Ever in Uses?	U.S. 13.							В	llack, White,	etc.
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ledica amine	al -			give stre	eet and numi	ber)		4b. City,	, Town, or	Location	of Death	Februa				5:30 I
e	edica mine ral cor	by Funeral Director	Aida F. E Aida F. E 4a. Facility Name (II Shady Gro 5. Social Security N 045-28-71 Usual Residence of	Aida F. Pagan 4a. Facility Name (If not institution, Shady Grove Adv 5. Social Security Number 045-28-7113 Usual Residence of Decedent	1. Decedent's Name (First, Middle, Last) Aida F. Pagan 4a. Facility Name (If not institution, give str. Shady Grove Adventi 5. Social Security Number 045-28-7113 Usual Residence of Decedent	Aida F. Pagan Aida F. Pagan 4a. Facility Name (If not institution, give street and num. Shady Grove Adventist Hose 5. Social Security Number 045-28-7113 Usual Residence of Decedent	Aida F. Pagan 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital 5. Social Security Number 045-28-7113 Usual Residence of Decedent Aida F. Pagan 7. Age (In yrs	1. Decedent's Name (First, Middle, Last) Aida F. Pagan 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 1 M 2 F 75 Yrs. Usual Residence of Decedent	1. Decedent's Name (First, Middle, Last) Aida F. Pagan 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital For O45-28-7113 Usual Residence of Decedent 1. Decedent's Name (First, Middle, Last) 4b. City Roc 7. Age (In yrs. last birthday) If Under Months	1. Decedent's Name (First, Middle, Last) Aida F. Pagan 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital Shady Grove Adventist Hospital For O45-28-7113 Usual Residence of Decedent O4001 D4001 Aida F. Pagan Ab. City, Town, or Pockvill Ab. City, Town, o	1. Decedent's Name (First, Middle, Last) Aida F. Pagan 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital Shady Grove Adventist Hospital For O45-28-7113 Usual Residence of Decedent Procedure: Name (First, Middle, Last) 4b. City, Town, or Location of Rockville Rockville 7. Age (In yrs. last birthday) Months Days Hours To Shady Grove Adventist Hospital Shady Grove How How How How How How How How How How	1. Decedent's Name (First, Middle, Last) Aida F. Pagan 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital For Shocial Security Number O45-28-7113 Usual Residence of Decedent 1. Decedent's Name (First, Middle, Last) 4b. City, Town, or Location of Death Rockville 7. Age (In yrs. last birthday) 1. Months Days Hours Min.	1. Decedent's Name (First, Middle, Last) Aida F. Pagan 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital 5. Social Security Number O45-28-7113 Usual Residence of Decedent 1. Decedent's Name (First, Middle, Last) 4b. City, Town, or Location of Death Rockville 7. Age (In yrs. last birthday) Months Days Hours Min. Nov. 2	1. Decedent's Name (First, Middle, Last) Aida F. Pagan 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital 5. Social Security Number O45-28-7113 Usual Residence of Decedent 1. Decedent's Name (First, Middle, Last) Aida F. Pagan 4b. City, Town, or Location of Death Rockville 7. Age (In yrs. last birthday) 1	1. Decedent's Name (First, Middle, Last) Aida F. Pagan 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital 5. Social Security Number O45-28-7113 Usual Residence of Decedent 1. Decedent's Name (First, Middle, Last) 4b. City, Town, or Location of Death Rockville Rockville Month Month Ac. Cou Month O45-28-7113 Usual Residence of Decedent	1. Decedent's Name (First, Middle, Last) Aida F. Pagan 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital 5. Social Security Number O45-28-7113 Usual Residence of Decedent 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year February 24, 2004 4c. County of Death Rockville Montgomer Adventist Hospital 7. Age (In yrs. last birthday) O45-28-7113 Usual Residence of Decedent

State of Maryland / Department of Health and Mental Hygiene ? = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Themistocle Papagjika February 23 2004 6:30 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2000 Bishop Castle Drive 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) **Funeral** Months Days Hours 86 Yrs. 380-30-6775 Director 1917 Albania Usual Residence of Decedent the Maryland r 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with items 23a or event, the Medical Examinar must be 2000 Bishop Castle Drive 20832 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Maryland 21215-0036 1 Yes 2 No þ Specify Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 16 owner / operator restaurant other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Importent: If item 27 ie marked o Constantine Papagjika Helen Papagjika 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haretine Papagjika - wife 2000 Bishop Castle Dr., Olney, MD 20832 Baltimore. rinjury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) importent: If any injury o Gate of Heaven Cem. 2-27-2004 Silver Spring, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21 Signature of Funeral Service Licenses once 11800 New Hampshire Av., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** cancer of the throat six months resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown <u>insulin</u> dependent diabetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\overline{\text{M}}\ \text{Residence} 6 Other (Specify) Hospital: 1 ☐ Yes 21 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No e Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) D37975 February 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey P. Indrisano, M.D. 10801 Lockwood Drive #280, SIlver Spring, MD 20901 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **FEB** 26 2004 Registrar

			1 - For State Registrar	State of Marylan		rtment of F			ene 9. No 200 L	07707
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	/Medic		Suzanne Janette P					Februar	y 21, 2004	
	Examir	er	4a. Fecility Name (If not institution, give s				r Location of Death	1	4c. County of Dea	
	Funeral		Montgomery Hospic 5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	Rockvil If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgo 9. Bir	thplace (State or Foreign country)
	Director		213-48-3629	M 2ᡚF 54	Yrs.	Months Days	Hours Min.	July 10		hington,DC
	tand 10W		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits
	Mary a-f sh	tor	Maryland Montgome:	ry P	otomac					1 ☐ Yes 2 ☑ No
	filed within 72 hours after death with the Maryland Hygiene. ther them eatural; or items 23a or 28a-f show ent, the Marinal Examinator unal be notified at	Director	10e. Street and Number	<u>.</u>	Comac	10f. Zip Code		10	g. Citizen of What Co	ountry?
	s 23a	ral	9201 Stapleford Ha			20854			US	
۲۵	ther de	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No	S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S _i an, Mexican, Puert	pecify Yes or No- Pican, etc.)	14. Race - Ame Black, Whi	
8	ral', o	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 🔀 No	Specify:		Specify:	Vhite
<u>у</u>	72 h	Completed	15. Decedent's Educ (Specify only highest grade		(Give I	ent's Usual Occup	during most of wor	king 1	6b. Kind of Business	
7	within ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retired	1)			
Maryland 21215-0036	Hygi Other	Be Co	17. Father's Name (First, Middle, Last)	4	Accou	ıntant	18. Mother's Nam	A C ne (First, Middle, M	counting aiden Sumame)	Firm
<u>Jar</u>	should be nd Mental marked o	To B	Vincent A. Pepper				Ann P	. Betscha	art	
Jan	2 short and rauma		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic svent, the Marical Examiner mad be notified at ance.		Vincent Pepper 20a. Method of Disposition	Father 20b. Pl	ace of Disnos	sition /Name of	d_Hall P		Enmac, Mar	vland 20854
<u>o</u> E	Pages Int: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☑ Other (Specify)	emoval from State Gate	emetery creme Of He	atory or other place	(a) 		Í	
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<u> </u>	80558		Buchard Y. H.	atio	500) Univers	ity Blvd	-W - Silv	lome, Inc. ver Spring	.MD 20901
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L	Examiner			Due to (or as a consequ	ience or):					
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9	tificat ng phy as the	Medic) (ST)	1200-						
Box	eath certific attending p for use as i	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of del	•
	at the dea	Physiclan/Me	1 Yes 2 No	4 ☐ Pregnant at time of de 9 ☐ Unknown	oath 5□	Other (specify)			Month	Day Year
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o c	<u>a</u> ≑ <u>a</u>	\vdash	27. Manner of Death		28b. Time of Injury	28c. Injury Work	4 Nursing no	28d. Describe how	ce 6 ⊠Other (Special of the control	Hospice
S	Attending r death. sctor: After y the fune	catlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆 '	Yes 2 □No			
Division of	7 9 5 5	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physical (Check only one)	ician: To the best of my know ler: On the basis of examinati and manner stated.	vledge, death ion and/or inve	occurred at the timestigation, in my or	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
		Σ	29b. Signature and title of certifier		No	29c. License	number	290	d. Date signed (Month	n, Day, Year)
	10		20 Nome and a district			D 356	35	Fe	bruary 21,	2004
		ĺ	30. Name and address of person who con Joseph Kaplan, M.D			•	d Pool	ville, MD	20055	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 4 200	32. Registrar's Signati	ure &	Spark		· • • • • • • • • • • • • • • • • • • •		

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	/Medic Examir		Vivian Fay Phil 4a. Facility Name (If not institution, g	Llips nive street and numbe	er)		4b. City, Tow	n, or Location of D			19 , 2004 c. County of De	
			1500 Highland D					ver Sprin			Montgom	
ı	Funeral Director		5. Social Security Number 6. 186-22-0447	. Sex 7 1 ☐ M 2 ☑ F	Age (In yrs. last bi 74	rthday) Yrs.	If Under 1 Ye Months Da			h. Dev. Yee	r) (irthplace (State or Foreign Country) nsylvania
	ס		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow				зату	219 1	. 929 - 011	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show many njury or other traumatic event, Ira Medical Exaction content is an appear.	10	Maryland Montgom	0.257								10d. Inside City Limits 1 ☐ Yes 2X No
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	tema tema	Funeral	11. Marital Status	12. Was Deceder Armed Force	s?	13. \	Was Decedent of Yes, specify C	of Hispanic Origin' Cuban, Mexican, P	? (Specify Yes o	or No-	14. Race - Am Black, Wh	nericen Indian, nite, etc.
336	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 £ If Yes, Give Year or Dates			1 ☐ Yes 22 亿 1					White
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9	he de	Physici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of death	5 🗆	Other (specify)			_	Month	Day Year
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UIVISION	l or At after of Direct I in by	Certification:	4 Homicide determined	A 256. Place of It	njury - At home, far etc. <i>(Specify)</i>	rm, stre	et, factory, offic	e	28f. Location City or	on (Street ar Town, State	nd Number or R e)	ural Route Number,
_	ospita hours uneral y fillec		29a. Certifier 1 Certifying Pl	hysician: To the bes	t of my knowledge	, death	occurred at the	time, date and pla	ace, and due to	the cause(s)	and manner as	s stated.
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Medical	one)	miner: On the basis and manners	øπ expamination and	d/or inve	estigation, in my	y opinion, death oc	ccurred at the tir	ne, date and	d place, and due	e to the cause(s)
	To With	Σ	29b. Signature and title off certifier	1//	// //	.,,		nse number			te signed (Mont	
	ν		30. Name and address of person who	oppoleted cause of	death (Item 23a)	type -	U,	052401		rebru	ary 20	, 2004
_			Thomas M. Annuli					e Ave. #3	305, Sil	Lver S	pring,	MD. 20904
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 X No 3 Probably 24a. Was an 24b. Were autopsy	ause of death? y 4 □Unknown
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25. Was case referred to medical examiner? 1 Yes 2 X No	ssisted iving
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2 Accident 3 Suicide 4 Homicide 2 Place of trijury - At home, farm, street, factory, office 2 Place of trijury - At home, far	d. e cause(s)
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day	r, Year)
D26259 February 23, 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)	2004
Ava A. Kaufman, M.D. 8218 Wisconsin Ave., #301, Bethesda, MD 20814 State State Begistrar State State Begistrar State Begistrar State State Begistrar State State Begistrar State Begistrar State S	

			For State Registrar		State o	f Maryl	and / Dep	artmen rtificat	t of H e of L	ealth a	and M		Reg. No	2004	077	90
	Divini di		1. Decedent's Name (First, Middle	, Last)								2. Date of D Month	Da	y Year	3. Time of 0	Death
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	Examin		4a. Facility Name (If not institution		eet and nu	mber)		4b. City,	Town, or	Location	of Death		4c.	. County of Death		
			1001 Lewis Ave	nue					kvil.					ontgomer		
	Funeral		5. Social Security Number	6. Sex	v 21€] F		vrs. last birthday) 7 Yrs.	Months		If Under Hours	Min.	8. Date of Bi (Month, P Sept. 1	rth ay, Ye <i>ar)</i>	9. Birth	plece (State or intry) e Islan	Foreign
	Director		039-12-2158 Usuel Residence of Decedent			/	7 Yrs.			L		Sept. 1	, 19	20 Knod	e Islan	ıa
	and w		10a. State 10b. County			10c.	City, Town or Le	ocation							10d. Inside City	y Limits
	f sho	ō	Maryland Montg	omerv	7	Ro	ckville								1 🖾 Yes	2 🗌 No
	28a	Directo	10e. Street and Number		<u></u>			10f. Zip	Code				10g. Cit	izen of What Cou	intry?	
	3a or		1001 Lewis Ave	nue				2	0851				Un	ited Sta	tes	
	death death	Funeral	11. Marital Status	12	. Was Dec	edent Ever i	n U.S. 13.	Was Dece	dent of H	ispanic Ori	igin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White		
9	atter or Ite		1 Never Married 2 Mar	bei	1 ☐ Yes If Yes, Gi	2 € No		1 ☐ Yes		Specify:		riican, etc.)				
21215-0036	be filed within 72 hours after death with the Maryland ale Hygiene. A let Hygiene de other than "natural", or items 23a or 28a-f show event, the Madical Extendion motal be notified at event.	dby	3 ☑ Widowed 4 ☐ Divorced		Year or D	ates:				ороопу.				Specify: Wh	rte	
'n	72 h	Completed	15. Deceden (Specify only highe	t's Educa st grade (ition completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	nk done	ation during mos	t of work	ing	16b. K	ind of Business/li	ndustry	
2	within	m m	Elementary/Secondary (0-12)		College (1-4or 5+)		sista:		')			,	Library		
N	filed within 72 Hygiene. ether than "ne's ent, the Medic	ပိ	17. Father's Name (First, Middle,	i ast)			AS	SISLa	111	18. Mothe	ar's Name	First, Middle	<u> </u>			
Maryland	ould be f Mental I arked of atic eve	Be	John J. Murray	2401/						Lula			,	,		
2	should nd Men marks umatic	ပ္	19a. Informant's Name/Relations	hip (Type	Print)		19b. Maili	na Address	(Street				oer. City o	or Town, State, Zi	p Code)	
<u>8</u>	ith an trau		Paula F. Bosti			ar.								land 217		
စ်	es 1 and 2 should be of Health and Mental f Item 27 is marked o r other traumatic eve		20a. Method of Disposition	C/ DC	augire.		b. Place of Disp	sition (Nat	ne of			Date	_	ocation - City or T		
Baltimore,			1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S		moval from		cemetery cre Montgo remator	omery	Taa	e) [F	'ebru 28, 2	ary 2004	D ~ +1	oodo M	amer 1 and	I
	Department Department Important: I any injury o		21. Signature of Funeral Service			10	remator 2	2. Name ar	nd Addres				Pump	nesda. M phrey Fu	neral H	ome/
ä	Dep Per Per Per Per Per Per Per Per Per Per		Atton /	11		M0068	9 R	ockvi	lle,	Inc.	300	West	Mont	gomery A 850-2805	venue,	
			23a. Pert Enter the disease, or shock, or heart failure. List	complica	ations that	caused the c	deeth. Do not en	ter the mod						330-2003	Approximate Interval Betw	
	Physician	Į	Immediate Cause (Final	Only One			structi	170 P11	1mon	arv D	licas	CA			Onset and D	eath
	/Medical		disease or condition resulting in death)	a.			sequence of):	vc ru	LIIIOII	ary D	1300	50				
	Examiner		Sequentially list conditions	b.	Peri	heral	. Vascul	ar Di	seas	e						
	D =	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	,	Due to	or as a con	s - uence of):									
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	D	/										
760,	be executed icien and burial-transit		,		000 10	(Or as a COII	sequence of):									
687	ys 9	dicai		d.												
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	230	c. If yes, ou	tcome of pre	egnancy							23d. Date of deliv	rerv	
Box	atter I for u	ciar	in the past 12 months?			oirth 2 □ f nant at time		□Ectopic pa □ Other (sp						Month		ear
O.	res that the de signed by the a be detached t	lysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown		9□ Unkr	own										
d	s that ned b	by P	Part ff. Other significent conditi	ons conti	ributing to c	leath but not	resulting in the	underlying o	ause giv	en in Part I		23e. Did	tobacco	use contribute to	the cause of de	ath?
g	w require been sig should b		Gangrene of f	eet								1□	Yes 2	□No 3★ Pro	bably 4 Ur	nknown
Records,	aw re	plet	Atrial Fibril	latio	on							24a. Wa	s an	24b. Were aut	opsy findings a	vailable
Ĭ.	The law cate has page 2	Completed	Coronary Arte	rv D	iseas	2						peri	ormed?	death?		230 01
ita	ıysician: Th iis certilicate director, paç	BeC	25. Was case referred to medica examiner?	-	10000					26. Place	of Death	(Check only				
<u>_</u>	d is	2	1 ☐ Yes 2X No	Но			2 ER/Outpatie	nt 3 🗆 D0	OA Oth	Br: 4 □ Nu	ursing Ho	me 5√€ Res	idence	6 ☐Other (Spec	fy)	
0			27. Manner of Death 1 X Natural 5 □ Pendii	ng	28a. Date (Mor	of Injury th, Day Yea	r) 28b. Time o	1	28c. Injun Worl	k?		28d. Describe	how inju	ry occurred		
Sio	Attending Production of the function of the fu	cati	2 Accident investi	gation				М		Yes 2 🗆						
Division of Vital		Certification:	4 Homicide determ		28e. Place build	e of Injury - A ling, etc. (Sp	At home, farm, si pecify)	reet, factor	y, office			28f. Location City or To	(Street ar	nd Number or Rui e)	al Houte Numb	ΘΓ,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely tilled in by		29a, Certifier 1 ∑ Certifyi	n Phuei	cian: To 45	a hast of mu	knowledge dee	th occurred	at the tio	ne date se	nd place	and due to the	cauca/a) and manner as	stated	
	24 hos Fun etely	edical	(Check only 2 Medicel	Examine	er: On the b	asis of examiner stated.	mination and/or in	rvestigation	i, in my o	pinion, dea	ath occurr	ed at the time	, date an	d place, and due	to the cause(s)	
	omple	Me	29b. Signature and title of certific					29	c. Licens	e number			29d. Da	te signed (Month	Day, Year)	
)	/		mula	(9	chl	or	~		D576	88			Febr	ruary 26	, 2004	
	12		30. Name and address of person				(Item 23a) (Type	, Print)								
			Meaza Gebresel						k Av	enue,	Gai	thersb	arg,	Marylan	d 20877	
	Sta	ite	31. Date filed (Month, Day, Year,		32. [Registrar's S	ignature /		park					-		
	Registi	ar	FEB 2	7 200	34	Seren	P	14	reservan	1						

		•	1 - State Registrar	State of M	aryland / Do	epartmei C <i>ertifica</i>	nt of H te of L	ealth a Death	ind Me	ental Hy	giene Reg. No	2004	07791
	Physici	an	1. Decedent's Name (First, Middle, La	st)	Pizzare	110				2. Date of De Month	Da	y Year	3. Time of Death
	/Medic		Laura Mari							Februa		. County of Deeth	10:30 A M
	Examin	er	4e. Fecility Name (If not institution, giv			1/1	, Town, or cmant	Location o	f Death		1	county of Deeth lontgomer	
			21222 Seneca Cros 5. Social Security Number 6. S		ge (In yrs. last birth		r 1 Year	If Under 2	24 Hrs.	8. Date of Bit	th	9. Birth	plece (State or Foreign
	Funeral Director			□M 21€7 F	51 Y	Months	Days	Hours	Min.	(Month, Da July 7	, 19	52 New	ntry) York
	р		Usual Residence of Decedent		10c. City, Town	and anation							10d. Inside City Limits
	ehow	5	10a. State 10b. County										1 ☐ Yes 2 ☑ No
	28a-1	ecto	Maryland Montgome 10e. Street and Number	ry	German		p Code				10a, Ci	itizen of What Cou	intry?
	with Ba or	<u></u>	21222 Seneca Cro	ssing Driv	re		376				-	ited Sta	
	ms 2:	Jera	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Deci	edent of H	ispanic Orig	gin? (Spec	offy Yes or No)-	14. Race - Ameri Black, White	
36	72 hours after death with the Maryland "netural", or Items 23s or 28s-1 ehow idical Expanded in and be neithed at	by Funeral Director	1 Never Married 2X Married	1 ☐ Yes 2 🛣 If Yes, Give	No	1 🗆 Yes		Specify:	i, r uono r	iloan, otc.)		-	nite
21215-0036	tural'	d be	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:		Decedent's Us	ial Occup	ation			16b. k	(ind of Business/Ir	
5	n n	Completed	(Specify only highest gr	de completed)		Give kind of w life. DO NOT	ork done	during most	t of workin	g			,
212	d within giene. r then	E O	Elementary/Secondary (0-12)	College (1-4or 5+		ter/ E	litor				Med	ical Wri	ting
Pu	e file al Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle	, Maider	n Sumame)	
<u>ylaı</u>	Ments Ments Prked	70	Alexander Schmidt							Rospi			
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other then " treumatic event, the Mar		19a. Informant's Name/Relationship (Joseph Pizzarello			-						or Town, State, Zi iantown,	
	1 and 2 Health em 27		20a, Method of Disposition		20h Place of [Disposition (N	me of			ate .		ocation - City or T	
Baltimore,	of 1		1 ☐ Burial 2 K☐ Cremation 3 [Monts Cremato	crematory or	other plac	F	ebrua 7, 20	ary			
Ħ	permit. Pag Department Important: I any injury o		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lipse	_	Cremato	_22. Name a	ind Addres	ss of Facilit	y Robe	ert A.	Pum	hesda , phrey Fu	neral Home/
Ba	permit. Departr Imports eny inj		> Affer) to		00689	Rocky	ille, ockvi	Inc. 11e,	300 Maryi	West l Land 20	Mont 3850	gomery A 2805	neral Home/ venue,
	Br. #		23a. Part 1. Enter the disease, or com	plications that cause one cause on each	ed the death. Do no								Approximate Interval Between
9	Physician		Immediate Cause (Final disease or condition		atic Panc	reatic	Aden	ocarc	inoma	a			Onset and Death 8 Months
	/Medical Examiner		resulting in death)	u	s a consequence of								
	Cxammer	<u></u>	Sequentially list conditions, if any, leading to minediate	b. Civa to for as	s a consequence of	n.							
	pet nsit	Examiner	Cause (Disease or injury	500 10 (51 41	3 a 30/1304a0/100 3/	,,							
·,	cate be executed physician and the burial-transit	Exai	that initiated events resulting in death) Last	c Due to (or as	s a consequence of	i):							
8760,	ysicia ysicia	dical		_ d									
9	certificate be executed ding physician and ise as the burial-transit	Medi	IF FEMALE:	-						20 			
Вох	death certific e attending p ed for use as f	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic						23d. Date of delive Month	Pery Year Year
0.	2 0 0	Physician/Med	1 ☐ Yes 2 ₺ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 Other (s	specify)						
9	law requires that the de as been signed by the a 2 should be detached f	Ph	Part II. Other significant conditions	contributing to death	but not resulting in	the underlying	cause giv	en in Part I.		23e. Did	tobacco	use contribute to	the cause of death?
Records,	uires sign	d by								10	Yes 2	No 3☐Pro	bably 4 Unknown
00	w requires been signatured is should it	lete								24a. Was		24b. Were aut	opsy findings available
Re	sician: The law certificate has b rector, page 2 s	Completed								auto perfe	psy ormed? 2½ No	death?	ompletion of cause of 2□ No
ital	ian: rtifica	BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only			
of Vital	Physician: this certific ral director,	2	1 ☐ Yes 2🛣 No	Hospital: 1 Inpat				4 140	-			6 □Other (Special	rfy)
n o		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. Ti ay Year) In	jury	28c. Injury Wor			8d. Describe	how inju	ury occurred	
sio	Attending r death. sctor: After	cat	2 Accident investigation 3 Suicide 6 Could not it	OB Place of Ir	njury · At home, farr	M street facto		Yes 2 🔲		8f Location	Street a	and Number or Rui	ral Route Number.
Division	after after Direction by	Certification:	4 Homicide determined	building, e	etc. (Specify)	III, Stiedt, iack	iry, onice			City or To	wn, Stat	te)	
	To the Hospital or Attending thin 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 (Check only one) (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the bes miner: On the basis and manners	of examination and	death occurre /or investigation	d at the tinen, in my o	ne, date an pinion, dea	d place, a th occurre	nd due to the	cause(s	s) and manner as nd place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title dispertifier	11		2	9c. Licens	e number		T	29d. Da	ate signed (Month	, Dey, Year)
) Oh.	10Man	com ?		D318	110			Fe	bruary 2	5, 2004
	10		30. Name and address of person who	completed cause of	death (Item 23a) (1	Type, Print)							
			Wayne L. Meyer, M	.D., 9715	Medical	Center	Driv	e, #2	14, I	Rockvi	11e,	Marylan	d 20850
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature		ock.						

			. For	State of M	aryland /	Depa	ırtmen	t of He	ealth a		ental Hyg		2	
		-	1 - State Registrar			Cer	tificat	e of E	Death			leg. No. 2	004	07792
ana ₹ D	hysicia	_	Decedent's Name (First, Middle, Last)								2. Date of Dea	Day	Year	7:0 / M
	/Medic	al	Josephir		etrone		4h Cihi	Tour	Location o	f Death	tebruar,		ZEC4	7.07 ***
E	xamin	er	4a. Facility Name (If not institution, give s Doctor's Communit				40. City,	Lank) Deali				eorge's
	ča i š	100	5. Social Security Number 6. Sec		ge (In yrs. last	birthday)	If Under	1 Year	If Under		8. Date of Birti (Month, Day			lece (Stete or Foreign
	neral ector			M 2 XF	83	Yrs.	Months	Days	Hours	Min.	Nov 3,	1920_		taly
P	>		Usual Residence of Decedent 10a. State 10b. County		10c. City. To	own orto	cation						1	0d, Inside City Limits
laryla	shov at at	5		Coores La				ا دادهد	١					1 ☑ Yes 2 ☐ No
the ₹	or 28a-1 show	rect	Maryland Prince 10e. Street and Number	George's			10f. Zip	erda]	re			10g. Citizen o	f What Cour	ntry?
with the	3a or		5505 59th Avenue	3					2073	7		1	USA	
IX 13-0050 within 72 hours after death with the Maryland ene.	natural', or Itema 23a otical Examinar musi L	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. \	Was Dece	ent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. R	ace - Americ	
after	or Ite	y Fu	1 ☐ Never Married 2 ☐ Married	1 ∐ Yes 2 🔀 lf Yes. Give	[No	i i	1 □ Yes		Specify:			Spec	eify:	
hours	ural,	d by	3 🖫 Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:		6a Decey	dent's Usua	al Occupa	ation			16b. Kind of		ute dustry
D 72	a nat	olete	(Specify only highest grad	le completed)		(Give	kind of wo	rk done d	luring most	t of work	ng			,
with jene.	T than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		Secr	etary	<i>Y</i>				Gover	nment
e filec	vent.	Bec	17. Father's Name (First, Middle, Last)						18. Mothe		(First, Middle,			
Vial buld b Menta	arked atic e	10	Stanislao Petror								smonda			
2 sho	.7 is marked other than "natural", or liema 23a or 28e-1 shov traumatic event, ILe Medical Examinar must be rediffed at		19a. Informant's Name/Relationship (T) Rose Petrone (Da	ope, Print) Bughter)	1		-				al Route Numbe erdale,			Code)
e, and 1 and Health	em 27 ther t		20a. Method of Disposition		20b. Place	a of Dispo	cition (Alar	no of	1		Date	20c. Location		own, State
ages ant of	nt: If it ry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Ft.	etery, crer Linco	natory or o	mete	ery	2/21	/2004	Bren	twood,	MD
E	a 3		21. Signature of Fun ral Service Licens			22	2. Name ar	d Addres	s of Facilit	y Ren	don/Hal	e Fune:	ral Ho	me
Dail permit Depart	any ir		> Aunaw	Ben.	los				-		ad, Lan		20706	5
1			23a. Party: Enter the disease, or comp shock, or heart failure. List only	ications that cause	ed the death. [Do not ent	er the mod	le of dying	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Phys	sician		Immediate Cause (Final disease or condition	C.W	ROUSE		RB	NE	ST					30 Min
	edical miner		resulting in death)	Due to (or a	s a consequen									let et
LAG		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a c sequen	ce of):	400	mu)un	\	NERO	LATER	7	MAN
pet	nsit	nine	Cause (Disease or injury	Co	VO W	nellar.		No.	wit.		Ours	down		14-40s
6U, be executed	sician and burial-transit	Examin	that initiated events resulting in death) Last	C. Due to (or a	s a consequen	ice of):				*	V-10-			17:
760 18 58 8	ysician ne buria	cal		d										
Records, P.O. Box 687 The law requires that the death certificate	by the attending phys tached for use as the	Physiclan/Medl	IF FEMALE:	"										
Box	or us	lan/	23b. Was decedent pregnant in the past 12 months?		e of pregnancy 2 Fetal de at time of deatl	ath 3]Ectopic p] Other (si						Date of delive Month	ery Day Year
O 월	the d	ysic	1 ☐ Yes 2 ☐ MO 9 ☐ Unknown	9□ Unknown	at thine of death	,, 5	_ Other (3)	decity)						
T tall	ed by	y Ph	Part II. Dther significant conditions co	intributing to death	but not resultir	ng in the u	inderlying	ause give	en in Part I	l.	23e. Did to	obacco use co	ontribute to the	he cause of death?
rds auires	been signed to should be deta	ed by	Type 7	Dire	FIES	1	VEL	FUT	us		10	es 2 No	3 ☐ Prot	pably 4 Unknown
S w re	s bee 2 shot	Completed	HUDBUT	01849	7						24a. Was		b. Were auto	ppsy findings available impletion of cause of
The	ate ha	E O	7, ,		70						perfo	rmed? 2 No	death? 1 ☐ Yes	20140
is ::	his certificate has t I director, page 2 s	Be	25. Was case referred to medical examiner?					0.1		e of Deat	h (Check only d	ne)		
Division of Vital Records, for Attending Physician: The law requires after death.	this call dire	2	1 Tes 2 10	Hospital: 1 Inpat		Outpatie			4 🗆 140	ursing Ho	me 5 Resident			(y)
ding F	After	lon	27. Manner of Death 1 Natural 5 □ Pending investigation	28a. Date of In (Month, D		Injury	м .	28c. Injun Worl 1 □	k? Yes 2□	No	200. 00301100 1	iow injury coo		
ISIC Attend death	ctor: y the	ficat	3 Suicide 6 Could not be	28e. Place of I	njury - At home	e, farm, st							mber or Rura	al Route Number,
Div	I Dire	Certification	4 Homicide	building,	etc. (Specify)						City or To	vn, State)		
Division of Vita To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director; After thi completely filled in by the funeral :		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the bes	st of my knowle	edge, deat	th occurred	at the tim	ne, date ar	nd place, ath occur	and due to the	cause(s) and date and plac	manner as s	stated. o the cause(s)
the H	the F	Medical	one)	and manner	stated.			c. Licensi				29d. Date sig		
5 ±	500	2	29b. Signature and title of certifier	n (\ A	Dear -	29	V. LICOIIS	\ (.	_		12 -	150	11
1	3		30. Name and address of person who	W M	V - HT	337 (I)	Print	ν	161	97		0)	NOU	4
(-)		30. Name and address of person who co		1332			2016	ا نہ	20.	(APHIN		m ?	NICL
100	St	ate	31. Date filed (Month, Day, Year)		strar's Signatur		ful	SACI	F '	* ')	- 1 M.W	~ /		
-6.	Regist		FEB 2 0 2004	Ellance	1	do	The state of the s							

				aryland / Depa	artment of Health and Natificate of Death	•	ene 2004 0779
	Physici /Medio		1. Decedent's Name (First, Middle, Last) DOROTHY PINN			2. Date of Death Month 2 18	Day Year 3. Time of Death 10:45 A M
	Examir	ier	4a. Fecility Name (If not institution, give street and number) ST. THOMAS MORE		4b. City, Town, or Location of Death HYATTSVILLE		4c. County of Death PRINCE GEORGE S
	Funeral Director			e (In yrs. last birthday) 32 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 3 29	ear) 9. Birthplace (State or Foreign Country) 1921 PENNSYLVANIA
	Maryland I-f ehow	tor	10a. State 10b. County MD PRINCE GEORGE'S	10c. City, Town or Lo	cation HELLVILLE		10d. Inside City Limits 1 % Yes 2 ☐ No
	with the 3a or 28s	i Director	10e. Street and Number 1906 WAESCH PLACE		10f. Zip Code		. Citizen of What Country?
920	d within 72 hours after death with the Maryland jiene. The Madical Examiner must be neilified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Never Married 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married	No I	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	vithin 72 ho ne. han "natur e Modical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give life. l	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	b. Kind of Business/Industry PRIVATE
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	and 2 should ealth and Men n 27 Is marke		19a. Informant's Name/Relationship (Type, Print) WANDA TATE/DAUGHTER		ng Address (Street and Number or Rur WAESCH PLACE MITO		
Baltimore,	t. Pages 1 rtment of He rtant: If iter njury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	FAMILY 1	PLOT 2-21-	-2004 WA	c. Location - City or Town, State ARSAW, VIRGINIA INS FUNERAL HOME
Ba	permi Depa Impo any i		23a. Pert1. Enter the disease, or complications that caused	74	474 LANDOVER ROAD	LANDOVER,	MARYLAND 20785
-	Physician /Medical Examiner		shock, or heart fail@re. List only one cause on each limmediate Cause (Final disease or condition resulting in death) a. ASP Due to (or as	IRATION PNI a consequence of): STERNAL M	EUMONIA	or respiratory arrest,	Interval Between Onset and Death
3760,	ate be executed nysician and he burial-transit	Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):			
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rds, P	w requires that the sbeen signed by the should be detache		Part II. Other significant conditions contributing to death be ENLARGED THYROID	ut not resulting in the ur	nderlying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐Unknown
Division of Vital Records,	The law ate has t page 2 s	Completed				24a. Was an autopsy performed 1 Yes 2 🔯	
Vita	Physician: Th rthis certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ent 2□ER/Outpatien	Othor	me 5 Residence	e 6 ⊡Other (Specify)
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		A	28d. Describe how in	
Divis	tal or Attu is after de al Directo ed in by ti	Certification;		ury - At home, farm, stre c. <i>(Specify)</i>	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Aural Route Number, itate)
	he Hospital on 24 hours at he Funeral Coletely filled i	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or inv	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the l within 2 To the l complet	Me	29b. Signature and title of certifier Augus Te	· · · · ·	29c. License number D19609		Date signed (Month, Day, Year)
) /	(3)		30. Name and address of person who completed cause of c RAMAN R. TULI M.D. 3503	eath (Item 23a) (Type, I	"	NTER MAR	YLAND 20712
	Sta Registr		31 Date filed (Month Day Year) 32 Begistr	ar's Signature			Market Ma

State of Maryland / Department of Health and Mental Hygiene 2001, 07796 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12, John Walter Perkins February 2004 $11:54 p^{M}$ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charlotte Hall Veteran's Home Charlotte Hall St. Mary's If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5, Social Security Number **Funeral** Days 1⊠M 2□F 82 22, December Director 579-18-6299 1921 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 27 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Mydical Examinar must be notified at 1 ves 2 No Director Maryland Millersville Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 749 Live Oak Drive 21108 U.S.A. Funerai 12. Was Decedent Ever in U.S Armed Forces? 1 Q/ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1943-1 ⊠ Yes 2 □ No II Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 1946 Specify: by White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within hand Mental Hygiene.
7 le marked other then Elementary/Secondary (0-12) College (1-4or 5+) Children's Medicine Pediatrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Basil Perkins Frances Gutshall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 Department of Health a Important: If Itam 27 is any injury or other tra Nancy L. Suter - Daughter 749 Live Oak Drive, Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Removal from State 1 Removal from State Ft. Lincoln Cemetery 2/19/2004 Brentwood, Maryland * 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee Constance Þ werd. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician wou disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit be executed Exami and resulting in death) Last Due to (or as a consequence of): Box 68760, hed by the attending physicien detached for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 4☐Pregnant at time of death 5 Other (specify) 2 No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed 2 No 2 1 No after death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Mann ol Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide ō within 24 hours a To the Funerel (Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified havalish 17/04 D0056949 It · D KARAKSHIBAIG K.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLATA KD-20646 CRAIN HW4 STE 102 LA 6620 31. Date filed (Month, Day, Year) State FEB 1 8 2004 Registrar

Ricardo O. Prout, Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item#Part II, PFR MC C331,5/26/0468d / Department of Health and Mental Hygiene 2 0 0 1,

1 - For Independ Item#23a,27,Per ME,0330,4/23/0468 Certificate of Death

Reg. No. 04-01538 crn 07795 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month February 29, 2004 **Physician** 12:37 PM Ricardo Quentin Prout, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Center Clinton 8. Date of Birth (Month, Day, Year) Nov. 17, 1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Days Hours Min. 1XM 2□ F 1949 Wash., 54 577-64-1858 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-1 show if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 💥 No Director Prince Georges Clinton the 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 9323 Pella Place 20735 Α. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If tem 27 is marked other there any injury or other trainment. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 No Specify. Specify: If Yes, Give Year or Dates Black þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Officer U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jesse H. Prout Frances James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ricardo Prout, Jr. / Son 9323 Pella Place, Clinton, MD 20735 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Maryland Natl Cem. 3/9/2004 Laurel, MD 22 Name and Address of Facility Bell Funeral Home, P. A. 21. Signature of Funjery Service Licens 6503 Old Branch Ave., Temple Hills, MD 20748 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on the cause on each line. Immediate Cause (Final dis are or condition Atherosclerotic Cardiovascular Disease **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): as the burial-Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Poorly Differentiated Colonic Adenocarcinoma, Metastatic to Liver 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1⊠Yes 2□ No 2□ No 1⊠′Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To SIL 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 01, 2004 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 RUSIO, MD ANA 82. Registrar's Signatuca

DRIVIH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

	Physiciar /Medica Examine
Y.	Funeral Director
	pu

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or Items 23s or 28s-f show

Baltimore, Maryland 21215-0036

Physi /Med Exan

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Eunarel Director: After this certificate has been sinned by the attending objectors and

Division of Vital Records, P.O. Box 68760,

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17. Father's Name (First, Mi	iddle, Last)				18. Mother's Na	ame (First, Middl	e, Maiden	Sumame)						
PILA	DES	SIMI		}		AMELIA		BOROTTI	[
19a. Informant's Name/Rela	ationship (Type, Print)		19b. Maili	ng Address (Street a	and Number or F	Rural Route Num	ber, City o	r Town, State,	Zip Code)					
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21. Signature of Funeral Se	ervice Ligensee	wal mo	(2. Name and Addres CHAMBERS I 5801 CLEVI	UNERAL	HOME & O	CREMA ERDAL	TORIUM,	P.A. 20737					
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DHMH 17 Rev 1/2001

FEB 17 2004

		4	For State Registrar	State of Ma	aryland / Dep	partment of Fertificate of			giene Reg. No. 200 L	07797
	Physicia /Medic	an al		A. Raymo	nd		- (2. Date of Dea Month Februar	Day Yeer	3. Time of Death 12:05 P.M
	Examin Funeral Director	eı		anor Healt	h Care e (In yrs. last birthda 85 Yrs.	Fre	derick If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 13,	Frede	
	Maryland I-f ehow		Usual Residence of Decedent 10a. State 10b. County Maryland Frederi	ck	10c. City, Town or Frederic					10d. Inside City Limits 1 ☐ Yes 2☐No
	h with the 23a or 28a at Le noti	Funeral Director	10e. Street and Number 5690 Barberry Co	urt		10f. Zip Code 21703	3		10g. Citizen of What Co USA	ountry?
5-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow or other traumatic event, Ita Medical Esaminar must be indifficat at		11. Marital Status 1 □ Never Married 2 ☑ Marned 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 If Yes, Give Year or Dates:	No	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, Whit	e.etc. nite
21215-0	d within 72 he giene. ir than "natu ir a Medical	Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+) (Gi	cedent's Usual Occu ve kind of work done DO NOT use retire	during most of work ed) Lcer		Law Enfor	
Maryland 2	should be filed withir nd Mental Hygiene. marked other than imatic event, ILa M	To Be C	17. Father's Name (<i>First, Middle, Las</i> Alrose Marsto				Rose Ca	therine	Maiden Sumame) Schirmer	
	1 and 2 sho Health and I sem 27 is ma other trauma		19a. Informant's Name/Relationship Regina Raymond/Wi		5690		Court, Fr		m, City or Town, State, 2 , MD 21703 20c. Location - City or	
altimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		20a. Method of Disposition 1	ify)	Resthav	en Mem. Pa 22. Name and Addr	ark 2/16/ ess of Facility Sta	2004 uffer F	Frederick, uneral Home	MD e, PA
68760,	Physician and physician and physician and physician and the brutal-transit	dical Examiner	23a. Parti. Eur the disease, or co- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of):	me II it		or respiratory ar	rest,	Approximate interval Between Onset and Death 2 w 5
O. Box	The law requires that the death certificate be exite has been signed by the attending physicien bage 2 should be detached for use as the burial	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. Il yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 Ectopic pregnand 5 Other (specify)	sy		23d. Date of de Month	livery Day Year
rds, P.	w requires that been signed t should be det	ed by P	Part II. Other significant conditions	contributing to death to		a underlying cause g	ven in Part I.		obacco use contribute to	o the cause of death? robably 4 Unknown
Vital Records,			hypertension dementia				. 7-14-7-2-1-1	1 Yes	osy prior to death? 2 No 1 Yes	utopsy findings available completion of cause of
Division of Vita	ng Phys fter this	Certification: To Be	25. Was case referred to medical examiner? 1	28a. Date of Inj (Month, Date of Injunction on December 28e. Place of Injunction of In	ent 2 ER/Outpa	e of 28c. Injury We M 1 [iry at ork?] Yes 2 □ No	ome 5 🗆 Resid 28d. Describe h	dence 6 Other (Spenow injury occurred	
Di	To the Hospital or Attendi within 24 hours after death, To the Funeral Director: A completely filled in by the fo	edical Cert	29a. Certifier (Check only 2 Medical Ex	Physician: To the best	of my knowledge, d	eath occurred at the novestigation, in my	time, date and place, opinion, death occur	and due to the	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the I within 2. To the I	Med	29b. Signature and title of certifier	and mangers	MY)		5 3 1 2		29d. Date signed (Mon	th. Day, Year)
	12		30. Name and address of person wh	218	W (oe. Print)	larex	ct fr	edenick,1	40 21703
1	St Regist	ate rar	31. Date liled (Month, Day, Year) FEB 1 9	2004 32. Regist	rar's Signature	Joles				

Walter RICL

VOID

CERTIFICATE

2004-007798

SEE

CERTIFICATE #

2003 - 44483

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	ate of Marylan		artment of H		nd Mental Hy	Reg. No.	2004	3. Time of Death
	Physici /Medic Examir	cal	4a. Fecility Name (If not institution, give street Anne Arundel Medical	and number)	dse_	4b. City, Town, o		Month	Day / 8	Year 2009 County of Deeth Anne Ar	205/M
	Funeral Director		5. Social Security Number 215-38-2518 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi Min. (Month, D Februa	ry 9,	9. Birth Cou 1911 Pe	plece (Stete or Foreign intry) nnsylvania
	death with the Maryland ims 23s or 28s-f show froust be notified at	irector	Usuel Residence of Decedent 10a. State 10b. County Maryland Prince Geor 10e. Street and Number	ges Bow	, Town or Lo	cation			10g. Citiz	en of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No intry?
0500-61	be filed within 72 hours after death with the Marylan stal Hygiene. ad other than "natural; or ltems 23a or 28a-f show event, the Medical Experience must be mailfied at	leted by Funeral Directo	1 Never Married 2 Married 1	Vas Decedent Ever in U. med Forces? ☐ Yes 2 ☑ No Yes, Give ear or Dates:	16a. Deced	20715 Nas Decedent of H Yes, specify Cuba I Yes 2 No Nent's Usual Occup kind of work done OO NOT use retirec	Specify:	n? (Specify Yes or N Puerto Rican, etc.)		A . 4. Race - Ameri Black, White, Specify: Wh	ite
7170	filed withir Hygiene. other than ent, the Ma	e Completed	Elementary/Secondary (0-12) C	College (1-4or 5+)		gistered	Nurse	s Name (First, Middle		rsing	
aryiand	2 should be and Mental is marked o	ToB	Herbert Scher 19a. Informant's Name/Relationship (Type, F	Print)			and Number	rah or Rural Route Numl		Town, State, Zij	obb
ore, mai	1 and Health em 27 ther tr		Linda Brannon/ Daugh 20a Method of Disposition 1 X Burial 2 Cremation 3 Remov	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other place	ce)	d, Bowie,	20c. Loc	ation - City or T	
Baitimore	permit. Pages Depertment of I Important: If Its eny injury or o		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Ft.	22	. Name and Addre	ss of Facility	/23/2004 Robert E. Road, Bo	Evan	s Funer	
,09/90	Cate be executed Medical Medical and and physician and the burial-transit	dical Examiner	23a. Par1. Enter the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause puisease or injury that initiated events resulting in death) Last d	ns that caused the death use on each line. Due to (or as a consequence to (or a))).	uence of):			ridiac or respiratory a			Approximate Interval Between Onset and Death
O. BOX o	the death certifically the attending phiched for use as the	Physician/Med	in the past 12 months?	yes, outcome of pregna □Live birth 2 □ Fetal □ Pregnant at time of de □ Unknown	death 3	Ectopic pregnancy			23	3d. Date of deliv Month	ery Day Year
cords, P	ires that signed b	by	Part II. Other significant conditions contribu	ting to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.		tobacco us		the cause of death?
Į,	The law ate has b page 2 st	Completed	1					24a. Was auto perf 1 \(\text{Yes}	opsy ormed?	24b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
DIVISION OF VITAL	To the Hospital or Attending Physicien: Th within 24 hours after death. To the Funeral Director: After this certificate completely filted in by the funeral director, pag	Certification: To Be	1 Natural 5 Pending 2 Accident investigation	tal: 1 Xnpatient 2 Da. Date of Injury (Month, Day Yeer) 3e. Place of Injury - At hobuilding, etc. (Specify	ER/Outpatien 28b. Time of Injury	28c. Injun Wor M 1	er: 4 🗆 Nursi	28f. Location	idence 6 how injury	occurred	al Route Number,
2	Hospital (24 hours at Funeral D tely filled in	ledical Cer	29a. Certifier 1 Certifying Physicial	On the basis of examinat	ion and/or inv	restigation, in my o	pinion, death	place, and due to the	cause(s) a	lace, and due to	o the cause(s)
	To the within ? To the comple	Med		and manner stated. Interpretation of the state of the st							
			30. Name and address of person who comple	eted cause of death (Item	23a) (Type.	Print)	16	1/9-2-	Cont	Ben	11,00
Ī	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 3 2004	32. Registrar's Signal	ture	books					

DHMH 17 Rev 1/2001

DANIEL

			1- State of Maryland /		artment of H		and Me		ene 20	04	07801
			Registrar 1. Decedent's Name (First, Middle, Last)		timodio or E	704111	-	2. Date of Death	. No	O Y	3. Time of Death
	Physici		Marjorie May Riley				İ	February	Day 7 21.20	Yeer 04	12:15 P ^M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location o			4c. County of	-	12.13.1
			4365 Harvey Road		Hunting	rtown			Calv	ert	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last to		If Under 1 Year Months Days	If Under a	Min.	8. Date of Birth (Month, Day, Y	ear)	9. Birthp Coun	lace (State or Foreign try)
	Director		470-05-7474	Yrs.				Jan. 29,	1920	Minn	esota
	land W		10a. State 10b. County 10c. City, To	wn or La	ecation					1	Od. Inside City Limits
	Mary -f sh	tot	Maryland Calvert Hunt	ingt	own						1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number		10f. Zip Code			100	. Citizen of W	hat Coun	try?
	th wit	aiΩ	2025 Lower Marlboro Road		206	39			U.S.A	•	
	ems erm	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of His If Yes, specify Cubar	spanic Orig	gin? (Spec	cify Yes or No-		- Americ	an Indian,
36	s afte	by Fu	1 Never Married 2 Married 1 Yes 217 No		1 ☐ Yes 2 ဩ No	Specify:		,	Specify:		nite
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-f ahow ha Madical Examinar must be notitled at	d be	3 ☑ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16	a Dogge	dent's Usual Occupa	tion		10	b. Kind of Bus		
5	in 72 n "na Nedic	Completed	(Specify only highest grade completed)	(Give	kind of work done di DO NOT use retired)	uring most	of workin	9	b. Kind of Bus	aness/inc	lustry
212	y with	mo	Elementary/Secondary (0-12) College (1-4or 5+)	secr	etary			D	C gove	rnmei	nt
פ	othe vent,	BeC	17. Father's Name (First, Middle, Last)			18. Mothe	r's Name	(First, Middle, Ma			
<u>Jar</u>	uld b Menta rrked rrked	To E	James Knight Scott			Till	lie	E.	Winte	er	
Maryland	2 sho and I is ma	g			ng Address (Street a						Code)
≥,	and ealth m 27				Harvey Rd						
Baltimore,	ges 1 t of H if ite or otl		i Le bullar 2 Cremation 3 Removal nom State		sition (Name of matory or other place		Da		c. Location - C		
Ë	t. Pa ntmen rtant: sjury	14			Veterans (3-1-2004	Chelte	nhan	n, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, it a Madical Examinar must be notified at once.		21. Signature of Funeral Service Licensee		Name and Address ausch Fun		•	, P.A.,	Owings,	MD	20736
Г	7		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ent	er the mode of dying	, such as	cardiac or	respiratory arrest	,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CH	IRONIC	01	BSTI	RUCTIU	3		Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence) Due to (or as a consequence)			1150	- A 8	=			
	Examiner		Sequentially list conditions, b.		<u> </u>						
	pe #s	ine	if any, leading to immediate Due to (or as a consequenc cause. Enter Underlying Cause (Disease or injury	a of):							
	ires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence	e of):							
8760,	be e sician buria	dicai E		/ ·							
687	ficate p physics the	edic	d								
Box	The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy						23d. Date	of delive	rv
m.	death e atte d for	icia	in the past 12 menths? 1 Ves 2 Page 4 Pregnant at time of death		Ectopic pregnancy Other (specify)				Mont		Day Year
o.	t the by the tache	hys	9 ☐ Unknown 9 ☐ Unknown								
s, P	gned oe de	by P	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause give	n in Part I.		23e. Did tobac	co use contrib	oute to the	e cause of death?
ğ	w require been si should b							1 Nes	2 □ No 3	☐ Proba	ably 4 □Unknown
Vital Record	law ras be	Completed						24a. Was an autopsy	24b. W	ere autop	esy findings available
~	The ate h page	Con						performe	de de	ath? Yes :	
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?				of Death	(Check only one)			care giver
o	Physician: The law rthis certificate has b ral director, page 2 s	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C			4 🗀 1401		e 5 🗆 Residend		(Specify,	hone
L	Sing I	ion	Natural 5 Pending (Month, Day Year)	Time of Injury	28c. Injury Work' M 1 TY	at ? es 2.⊟N		3d. Describe how	injury occurred	3	
Division	death. ctor: A y the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	farm str		03 2 01		If. Location (Stree	t and Number	or Rural	Route Number
2	after Direct	Certification:	4 Homicide determined building, etc. (Specify)		561, 126651 y , 61166			City or Town, S		D2 710101	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Certifying Physician: To the best of my knowled (Check only 2 Medical Examiner: On the basis of examination a	ge, death	occurred at the time	e, date and	d place, ar	nd due to the caus	e(s) and man	ner as sta	ited.
	To the H within 24 To the F complete	fedical	one) and manner stated.	ind/or in			III OCCUITIOC	at the time, date	and place, an	0 000 10	trie cause(s)
,	To Toon	Σ	29b. Signature and title of certifier MD		29c. License	number	2 7	29d	Date signed (Month, E	Day, Year)
'			Allendy Phys	- 6-	1	194	9/	o o	100	1	
	٦		30. Name and address of person who completed cause of death (Item 23a						1	94.004	
	Sta	10	A.T. Munshi, M.D. 110 Hospital R 31. Date filed (Month, Day, Year) 32. Registra Signature	d.,	Suite 303	, Pri	ince -	Frederic	k, MD-	206	78
	Registr		FEB 2 3 2004) Moses	K	Soules						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy February 20,2004 Mae Rhine 5:50 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 471 Deale Road Deale Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F Director 577-16-2921 90 March 11, 1913 Washington, DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2V No Maryland Director Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 0 471 Deale Road 20751 U.S.A. 230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? or Iteme Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marilal Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white Be Completed by 3 Widowed 4 □ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) legal secretary 12 patent attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked off jury or other traumatic even William Η. Lillian Marie Hildebrand 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara R. Howard, daughter 1342 West River Rd., Shady Side, MD 20764 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery Feb. 24,2004 Brentwood, MD 21 Signature of Funeral Service Licials 22. Name and Address of Facility elbar Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of). use as t the attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death for in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to leath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Pes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page Thures 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ER/Outpatient Certification: To 3 DOA 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending Injury 1 Tes 2 No 24 hours after death. 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and address who completed cause of death frem 23a) (Type, Print) 31. Date filed (Month, Day, 82. Registrar's Signature State 2004 Registrar

		1 - For State Registrar	State of Maryland	d / Depa	artment	t of Hea	alth and	Mental Hy	giene	2004	07803
Physicia		Decedent's Name (First, Middle, Last) Dorothy Elizabeth	h Reeser					2. Date of De Month Februa	Day	7 200	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give st			4b. City,	Town, or Lo	cation of Dea			ounty of Death	
		11615 Pinesburg Ro			If Under		amspor	†	-th	Washir	ngton plece (State or Foreign
Funeral Director		219-12-2232	7. Age (In yrs. la	Yrs.	Months		Hours Min		1921	Penn	piece (State of Poreign intry) Sylvania
and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside City Limits
Maryl	io	Maryland Washin	gton		Will	iamsp	ort				1 ☐ Yes 2 💆 No
or 288	Oirec	10e. Street and Number			10f. Zip				10g. Citize	n of What Cou	entry?
ath w	rai	11615 Pinesburg Ro		C 123	Man Dagge	217		Specify Ves or N	On 14	USA Race - Amer	ican Indian
permit. Pages 1 and 2 should be lited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene are the action of Health and Mental Hygiene. Buy injury or other traumatic event, it a Medical Evantmer must be available at an annual beautified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 	1	was Deced If Yes, spec 1 ☐ Yes		Mexican, Pue Specify:	Specify Yes or N to Rican, etc.)		Black, White pecify:	, etc.
2 hour	ted t	15. Decedent's Educ	cation	16a. Dece	dent's Usua	al Occupation	on	akin a	16b. Kind	Wh.	
within 72 ane. then n	Completed	(Specify only highest grade	College (1-4or 5+)			one duri se retired) Opera	ing most of wo itor	orking		Grocei	^ y
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lid be fental rked c	To Be	George Dewey A	mbrose				Mary	Catheri	ne Jo	rdon	
and N	-	19a. Informant's Name/Relationship (Typ			3	,		lurai Route Numi			
and 2 ealth m 27 in		Ronald Reeser - So). Box		Shephe	rdstown,	-	Virgin ation - City or 1	
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t. Partmen rtant:		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			- Anna Carlotte			- 17		amspor	t,Maryland
Department of the policy of th		21, Signature of Futheral Service Classes						me, P.A ue St.W		sport 1	4D 21795
上 卷 4 1 4		23a. Part1. Enter the disc ase, or complic shock, or heart for ire. List only on	cations that caused the death	n. Do not ent	ter the mod	le of dying,	such as cardia	c or respiratory	arrest,	.sp o / 1,1	Approximate Interval Between
Physician		Immediate Cause (Final		- (Æ	900	ancre				nset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequ		1.6		- PICIE	45			
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ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	Jence of):							
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e death	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (sp	pecify)					,
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The law requires that the death certifical are been signed by the attending phypage 2 should be detached for use as the	d by							1	Yes 200	No 3□Pro	bably 4 Unknown
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The la	E O							per 1 ☐ Yes	opsy formed? 2 No	death?	ompletion of cause of 2 No
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Physic Physic rthis ce	To	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐				4 Nursing	Home 5 Res			sify)
nding Physician: The lav nding Physician: The lav tth:: After this certificate has 9 funeral director, page 2	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	of 2	28c, Injury a Work?	t s 2 □ No	28d. Describe	now injury	occurred	
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To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier Certifying Physical (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurred evestigation	at the time, n, in my opin	date and place nion, death occ	ce, and due to the curred at the time	e cause(s) a e, date and p	nd manner as place, and due	stated. to the cause(s)
within 2 To the complet	Mec	29b. Signature and little of certifier	2		29	c. License n	number		29d. Date	signed (Month	, Day, Year)
A.		1 / Korar I hon	man b. Ph	D. M	D	ロリク	511		Feh	ryaru	17,2004
W. W.		30. Name and address of person who co		n 23a) (Type,	Print)				10411 12	0000	17, 2004 4 C. 1Km
3,		////-	apus Rd. St	1. 130	Ha	gensi	tuein,	ma, 2	1.142)	7	m.L
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture Ø. A	parte	/					

Amended #s 5, 12, 28a, 28e; nls, 2/17/04, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Allegany Co. Amend Item #23b per phy G830 65 incate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last, 2. Date of Death Feb 14 2004 **Physician** 5:22PM Rideoutt Harry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cumberland Examiner ALTegany Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 232-22-6165 Director 82 Oct.15,1921 W. Va. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits i Hygiene. other then "natural", or Items 23a or 288-1 arro-rvent, the Medical Examiner must be realified at WV Ne Yes 2 No Mineral Keyser Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 226 Virginia Street 26726 U.S.A. by Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 13379 ≥ 2 □ No WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Engineer Construction 8th of Health and Mental Hygic litem 27 is marked other in r other traumatic event, in 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry S. Rideoutt, Sr. Pearl Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne A. Spriggs 7398 Branleigh Park Court, Reston, VA 20191 it of Health : Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of Important: If eny injury or Scarpelli Crematory2/16/04 Cresaptown, MD 22. Name and Address of Facility
Markwood Funeral Home, 21. Signature of Funeral Service Licensee Hawle Dea P.O. Box 912, Keyser, W 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 912, Keyser, WV 26726 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Intracerebral Bleeding resulting in death) /Medical Due to (or as a consequence of): Examiner Traumo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed resulting in death) Last physicien an s the burial-tr Due to (or as a consequence of): Box 68760, Physician/Medicai Pas 14. attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year ö 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached t Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tes 2 No or Attending Physician: 25. Was case referred to medical examiner?released
Yes 2□No Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို this 28a. Date of Injury
02 (Month 1014 Year)
12b. Time of Injury
8:00PM M 1
28b. Time of Injury
Wo
12b. 28c. Injury
No. Plac of Injury - At home, farm, street, factory, office building, etc. (Specify) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 2 Accident 3 Suicide 1 ☐ Yes 2 🗙 No sub fell while bowling 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Bowling Alley Keuser West Virginia To the Hospital 1x C rill i g P sician: o the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man or as status.

2 Met - Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of ce 8 D23167 FEBRUARY 15, 2004 30. Name and address of person who combleted cause of death (Item 23a) (Type, Print) n RS JUAN A. ARRISUENO, M.D., 902 SETON DRIVE, SUITE 205, CUMBERLAND, MARYLAND 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signatuse State 1 7 2004 FEB Registrar

			For State Registrar	State of Marylan	d / Depa	artment of He tificate of D			iene ig. No. 200	+ 07805
			Decedent's Neme (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Grace Mary Ras	sa [′]				February		11:00 P M
	Examin		4a. Fecility Name (If not institution, give str	reet and number)		4b. City, Town, or L			4c. County of Dea	th
			Holy Cross Hospi			Silver S			Montgom	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. M 2⊠F	Ven	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplece (State or Foreign ountry)
	Director		578-24-2621 Usual Residence of Decedent	79				April 4,	1924 Was	shington, DC
	and ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mary First	to	Maryland Montgomer	sy Si	lver S	pring				1 ☐ Yes 2 反 No
	r 288	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of What C	ountry?
	death with the Maryland ims 23e or 28e-f show remail be notified at		411 Royalton Road	i		2090			USA	
	r dea	Funeral	11. Wantai States	Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of His f Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am- Black, Whi	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: Wh:	ite
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yla	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than 'natural', or itams 23a or 28a-1 show sumatic event, the Medical Exeminer must be neitilised at	ဥ	Antonio LaRosa			(0)	Rose Co		C: T C:	7:- 0:-(-)
Maryland 21215-0036	l 2 sh and r is m		19a. Informant's Name/Relationship (Typ		1				City or Town, State,	
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وّ	Pages nit: Hit		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State Cat	e of F	natory or other place. leaven	repru		41 C	
Baltimore,	그는무금		* 4 □ Donation 5 ②XOther (Specify) } 21. Signature of Funeral Service License			 Name and Address 	of Facility		7.00	ing, Maryland
Ba	Depar impor eny ir		1 200		F	rancis J. OO Univers	Collins	Funeral	Home Inc.	no. MD 20901
760,	iste be executed // Medical Examine parial-transit the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease of injury that infiliated events resulting in death) Last	Metastatic Due to (or as a consecutive to (or a))).	Endome quence of):					Onset and Death
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ord	w require been si should	eted						-		
I Records,	The law cate has b page 2 sl	Completed						24a. Was an autops perform	y prior to ned? death?	utopsy findings available completion of cause of s 2 No
Vital	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only on	e)	
7	Physician: this certific ral director,	은	1 ☐ Yes 2 🔀 No		ER/Outpatie		4 Nursing Ho		ence 6 Other (Spa	ecify)
Division of	fing After fune	atlon:	27. Manner of Death 1 ⊠Naturel 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work'	at ? es 2 □ No	28d. Describe no	ow injury occurred	
Divis	Digital of	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office		28f. Location (Sti City or Town	reet and Number or F n, State)	lural Route Number,
	e Hospital or 24 hours afte Funeral Dir etely filled in	Medical (29a. Certifier 1 △ Certifying Phys (Check only one)	sician: To the best of my kn ner: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurred at the time exestigation, in my op	e, date and place, inion, death occurr	and due to the ca ed at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	within 2. To the I complet	Me	29b. Signature and little of certifier	1 1	2	29c. License	number	25	9d. Date signed (Mon	th, Day, Year)
	15		1.12. 4	Sand	· w	D5226	51		February	15, 2004
			30. Name and address of person who co	/			150			
			Alan R. Segal M.D			le, Silver	Spring,	MD 209	06	
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 8 201	32 Registrar's Sign	Aure 19	Sporks				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1.

		_1	For State Registrar	State of Marylan	Cei	tificate of	Death		eg. No.	3. Time of Death
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last) FRANCES IRENE					Month FEBRUARY	Day Yea 7 13, 2004	5:30P. M
	Examin	er	4a. Fecility Name (If not institution, give s				r Location of Death	1	4c. County of De	
_			9262 Cherry Lane, 5. Social Security Number 6. Sex	#40 7. Age (In yrs. i	last birthday)	Laurel If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	Prince C	Birthplece (State or Foreign Country)
	Funeral Director		214-28-4829		85 Yrs.	Months Days	Hours Min.	July30,	1918 W	country) ashington,D.C
	yland		Usuel Residence of Decedent 10a. State 10b. County		y, Town or Lo	cation				10d. Inside City Limits
	the Ma	ectol	Maryland Prince Ge	eorge's La	urel	10f. Zip Code		1	0g. Citizen of What	1 ☐ Yes 2 ☑ No Country?
	23e or	al Dir	9262 Cherry Lane,	#40		207			United St	ates
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other then "naturel", or Iteme 23e or 28e-f show envi Injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2V No If Yes, Give Year or Dates:		Was Decedent of HII Yes, specify Cub 1 ☐ Yes 2 ☐XNo	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc. White
Baltimore, Maryland 21215-0036	within 72 ho ane. Iben "natur se Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of wor		16b. Kind of Busine Federal G Dept. of	The state of the s
7 pt	e filed al Hygie other	Be Co	17. Father's Name (First, Middle, Last)		Deere	cur j	18. Mother's Nan		Maiden Sumame)	
ylai	J Menta	To	Dellburt 19a. Informant's Name/Relationship (Type		dwell	na Address /Straet	Esther	ıral Route Numbe	Soude r, City or Town, State	
Ma	alth and 2 sl		Ronald W. Richard	s -son	1168	0 68th A	ve. Semin		rida 3377	
ore,	ges 1 a		20a. Method of Disposition 1	20b. For smoval from State	Place of Dispo	esition (Name of matory or other pla	^{∞)} Cem 2/17	Date /2004	20c. Location - City Adelphi,	
altim	nit. Pa partmen ortant: injury		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License				1		l Home, P	
Ä	imp eny		23a. Pert1. Enter the disease, or complishock, or heart lailure. List only on	Mill Ro	ad Rolte	wille Ma	- A - ryland 20705 Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cerebral A	neurys		7,1,0	<u></u>		1 year
ı	Examiner		Sequentially list conditions	Due to (or as a conseq	uence or):			·		
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
68760,	ificate be executed g physician and as the burial-transit		that initiated events resulting in death) Last	Due to (or as a conseq	uence of):		-			
-	= 00 0	Medicai	IF FEMALE:		-					
.O. Box	The law requires that the death certifate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√□ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fete 4 Pregnant at time of of 9 Unknown	I death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
4	w requires that s been signed b should be deta	by	Part II. Other significant conditions cor	tributing to death but not res	sulting in the u	inderlying cause gi	ven in Part I.			e to the cause of death? Probably 4 Unknown
Division of Vital Records,	The law recate has bee	Completed						24a. Was a autop perfor	sy prior	
ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?					ath (Check only or	ne)	
7	9 5	2	1 ☐ Yes 2√2 No	lospital: 1 Inpatient 2	-	III 3LI DOA			ence 6 Other (S	Specify)
ion o	afte and	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer)	28b. Time o Injury	Wo	ryat ork?]Yes 2. □No	28d. Describe h	ow injury occurred	
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special		reet, factory, office		28f. Location (S City or Tow	treet end Number o n, State)	r Rural Route Number,
	24 hour 25 hour Funer stely fills	edical	29a. Certifier 1⊠ Certifying Phy: (Check only one) 1 Medicel Exami	sician: To the best of my knoner: On the basis of examinating and manner stated.	owledge, dear ation and/or in	th occurred at the to execute the total the to	ime, date and place opinion, death occu	e, and due to the durred at the time, d	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	omple	Me	29b. Signature and title of certifier			29c. Licen			29d. Date signed (M	onth, Dey, Year)
	ML		· A pue			D36	716		February	16, 2004
	\$10		30. Name and address of person who co Andrew Kundrat, M.		m 23a) (Type 8317 C	. Print) herry Lar	e Laurel	, Marylar	nd 20707	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature &	Some	61			

State of Maryland / Department of Health and Mental Hygiene 2004 07807 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Claudia P. Richardson February 2004 13. 11:35P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5459 Woodland Boulevard Oxon Hill Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X Months 579-58-0171 60 Director June 8, 1943 Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show it of Health and Mental Hygiene.
If Item 27 is marked other than "naturel", or Items 23a or 28a-f show or other treumstic event, the Medical Examinar must be notified. XX Yes 2 ☐ No Directo Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 5459 Woodland Boulevard United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: Afro-American 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Supervisor (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Document & Records Control U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Wooter Johnson Burnice Sharpe 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Richardson (husband) 5459 Woodland Blvd., Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If ony injury or ¹ 4 □ Donation 5 □ Other (Specify) 2/20/04 Ft. Lincoln Cemetery Brentwood, Maryland 21. Signaturant Funeral Service Licensee 22. Name and Address of FacilitMcGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Renal Cell Carcinoma /Medical Due to (or as a consequence of) Examiner Metastatic Cancer of Neck & Lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exan iner Hospitel or Attending Physician: The law requires that the death certificate be execused burial-trai Due to (or as a consequence of): P.O. Box 68760 physicien Physician/Medical the use as I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ gig Pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes X No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home XXResidence 6 Other (Specify) 1 ☐ Yes 2 🗓 No Certification: To 3□ DOA 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ANatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funerel Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie completely (Chack only one) ro the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4360 (D.C.) February 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dal Yoo, M.D. 110 Irving Street, N.W. Suite CG-184 Washington, D.C. 31. Date filed (Month, Day, Year) FEB 2 0 32. Registrar's Signature State 2004 Charles racks Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month February 15, 2004 2:00 PM Joseph R. Ritondo /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner 2503 Lindell Street Montgomery Wheaton If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 20, 1909 Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 95 Yrs 113-12-5628 Director Italy Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or Items 23e or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2503 Lindell Street 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 h marked other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If Item 27 is marked other it
eny injury or other treumatic event, Ite
once. Carpenter Federal Government unould be fi.
Ith and Mental Hy
7 is mark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cataldo Ritondo Josephine Farara 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Livia C. Ritondo/ Wife 2503 Lindell Street, Wheaton, MD 20902 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State February 19 2004 1 2 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Fyneral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 23a. Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxia 6 minutes /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed attending physician and for use as the burial-transit Advanced Age 10 years Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown been signed by should be detac ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Spinal Stenosis 1 Yes 2 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: Injury 1 XNatural 5 Pending investigation il or Attendin after death. I Director: Aff d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital owithin 24 hours at To the Funeral D 29a. Certifier 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D0033109 February 15, 2004 30. Name and a cress of person wno completed cause of death (Item 23a) (Type, Print) Adolph W. Johnson M.D. 12520 Prosperity Drive, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 0 2004 sacker Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 5:45 P M Dolores Robinson Reback February 15, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F 80 Yrs Director Tennessee 413-26-6785 Apr 13, 1923 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examinar is ust be notified at 1X Yes 2 □ No Director Maryland Rockville Montgomery 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 20852 6121 Montrose Rd USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Š 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 2 Homemaker Own Home other traumatic svant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event Morris Benjamin Robinson Rose Etkind 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sanford Reback/Son 7516 Sebago Rd, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Feb 17, 2004 Olney, MD Judean Mem Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part) Enter the disease, or empirations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) NEUMONIA Physician /Medical **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner and that initiated events resulting in death) Last physicien ar Due to (or as a consequence of). Physician/Medical as the attending IF FEMALE use a 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ eq. 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 70 1 ☐ Yes 25 No Sich 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur, and title of term or D18084 FEBRUARY 15, 2004 140 who completed cause of death (Item 23a) (Type, Print) MONTROSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

FEB 25

2004

Maryland 21215-0036

Baltimore,

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	1	For State Registrar	State of N	/larylan	id / Depa	artment of F	lealth and M <i>Death</i>		giene 2 (04	07810
Physiciar /Medica	n	Decedent's Name (First, Middle, Last)	Kalee	1 S.	Rizk			2. Date of Dea Month Februar	Day	0°04	3. Time of Death 5:22 P M
Examine	r	4a. Facility Name (If not institution, give s Suburban Hospi	tal			4b. City, Town, o Bethes If Under 1 Year				gome	
Funeral Director		5. Social Security Number 148-10-9940 Usual Residence of Decedent	M 2□F	93	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day March 2	6, 1910	9. Birthp Cour Syr	lace (State or Foreign itry) 1.a
permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show enry injury or traumatic event, Ite Medical Evantical mant be notified at once.		10a. State 10b. County Maryland Montgome	ry	10c. Cit	ty, Town or Lo	ville				1	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
3a or 28	5	10e. Street and Number 6134 Lux Lane				10f. Zip Code 2085	52		10g. Citizen of V United		
al, or Itams 2 Examinar mu	by rur	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 1 K Yes 2 E If Yes, Give Year or Dates	s?]No 19	131	Was Decedent of H If Yes, specify Cubin	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	ck, White,	
the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		r 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired ronic Eng	during most of work d)	ing	Governm Contrac	nent	dustry
atic event,	lo Be C	17. Father's Name (First, Middle, Last) Saleem K. Rizk						a Fatood	ch		
r traum		19a. Informant's Name/Relationship (Ty Anne D. Rizk / Wi			1		, Rockvil				Code)
ry or othe	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from Sta	te	cemetery, crei	sition (Name of matory or other place ven Cemeter	^{сө)} ¦Februa	ery 20,	20c. Location - Silver Sp		
Importa eny inju once.	I	21. Signature of Funeral Service License		м0130	5 Ro 30	Name and Address bert A. Pur West Mon	ess of Facility ophrey Funer tgomery Aver	cal Home/i	Rockville ville, Ma	, Inc.	1 20850–2805
sician and dical fransit sthe prival francial street street and street street and street street and street	dical Examiner	23a. Pant1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Pro Due to (or a	ı line.	cance of):		ng, such as cardiac c	or respiratory ar	rest,		Approximate Interval Between Onset and Death
detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death 3	Ectopic pregnanc Other (specify)	у			te of delive	ery Day Year
		Part II. Other significant conditions con Alzheimer's Disea	_		-	nderlying cause gr	ven in Part I.	III.			ne cause of death?
page 2 should	Completed by							24a. Was autop perfor 1 Yes	rmed?	Were auto prior to cor death? 1 Yes	psy findings available mpletion of cause of 2 No
When this cuneral dire	Certification: To Be	27. Manner of Death 1 2 Natural 2 Accident 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	dospital: 1 ☐ Inpa 28a. Date of In (Month, I	njury Day Year)	28b. Time of Injury	f 28c. Injui	Yes 2 □ No	me 5 Resid 28d. Describe h	dence 6 Oth	red	
3 2 2		4 Homicide determined 29a. Certifier 1 Certifying Phy	building,	etc. (Speci	fy)	h occurred at the fi		City or Tou	vn, State)		I Route Number,
within 24 ha To the Fun completely	Medical	(Check only 2 Medical Exami	ner: On the basis and manner	s of examina	ation and/or in	vestigation, in my o	opinion, death occurr	red at the time, o	date and place,	and due to	the cause(s)
1	-	29b. Signatule and tale of certifier at 30. Name and address of person who co	ompleted cause of	MZ of death (Item	m 23a) (Type	D005	57896		29d. Date signe Februar		
		David Hirshfield, 31 Date filed (Month, Day, Year)	M.D. 1	0215	Fernwo	,	Bethesda	, Maryla	and 2081	.7	
Stat Registra		FEB 2.3 200		strar's Sign	G	South					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:00 P M Martha Folkedahl Rogers February 24, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. Davs 1 ☐ M 2 🖼 F 026-20-4256 80 Mar. 29, 1923 Director Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County iral', or items 23a or 28a-f show Exar-instricted at 1 ☐ Yes 2 ☒ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 20910 8560 Second Avenue, Apt. 1718 IISA Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.

The popertment of Health and Mental Hygiene.

The monotrant: If them 27 is marked other than "natural; or flee file minimate.

The monotrant is the property of the standard over the Medical Enacinary. 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Alice Hamel Frank L. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David D. Rogers/ Son 7201 Smitten Farm Lane, The Plains, VA 20198 20b. Place of Disposition (Name of cemetery, crematory or other place) February 26 20c. Location - City or Town, State 20a. Method of Disposition injury or g 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially but conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ns1071 certificate 0 2⊠ No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☐ No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation Natural within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🛀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Chack only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D55403 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH K. KHETAN, MD 7610 CALROLL AVE #260, TAKONA PARK MD 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks! FEB 27 2004 Registrar

1000	Phy /N Exa	/sicia: ledica amine
x 68760,	certificate be executed	iding physician and ise as the burial-transit

		1	= For State RegistramEND ITEM #5 PER	State of Marylar FH G 830 4/02	nd / Depa 2 / 04 10 e	artment of He rtificate of D	ealth and Mer	ntal Hygien Reg. N	^e 2004					
	Physicia	- 10	1. Decedent's Name (First, Middle, Last)					Date of Death Month Debruary	17, Year 20	3. Time of Death 0 4 2015 ^M				
	/Medic	al	Ofelia A. Rosanov ta. Facility Name (If not institution, give st			4b. City, Town, or L			c. County of Death					
	Examin	er		emorial Ho	spital	Eas	ston		Talbo					
	Funeral Director		5. Secial Security Number 6. Sex 213-76-7972	M 2⊠F 7. Age (In yrs. 67	. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Yea arch 25,]	r) 9. Birth Cod 1936 Ita	plece (State or Foreign intry) 1 y				
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits				
	Mary -f eh	to	Maryland Caroline	Pr	eston					1 X Yes 2 No				
	or 28c	Director	10e. Street and Number			10f. Zip Code			Citizen of What Co	untry?				
	23a c	ral	4798 Birch Road			2165.	5		U.S.A.	ican Indian				
3	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Markal Exama as must be notified at or other traumatic event, the Markal Exama as must be notified.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 	-	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2X No	Specify:	an, etc.)	Black, White	, etc.				
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	be filed ital Hygi id other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name (F		en Sumame)					
2	Ment Ment arkec	ဥ	Giulio Iaccino		401 44 3	ng Address (Street ar	Carmela		y or Town State 7	in Code)				
0	2 shou and M I e mar	li	19a. Informant's Name/Relationship (Typ											
	1 and 2 Health tem 27		Giulio Rosanova - 20a. Method of Disposition		Place of Disp	Compass Consistion (Name of matory or other place)	Date Date	el, Mary	Location - City or	Town, State				
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banninore,			21. Signature of Funeral Service License			2. Name and Address		007						
Ö	permit. Departr Importe any inju		1 / placet (1)	May	4	739 Baltin	more Ave.,	Hyattsv						
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	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		MONU	2				Feb/04,				
8/60,	cate be executed physician and the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a conse	n toye	reval	disease			years				
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<u>a</u> .	uires that signed by	by	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the	underlying cause give	n in Part I.	23e. Did tobacc		the cause of death?				
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ot <	Physicien: The lithis certificate har all director, page	2	1 Yes 25No		☐ ER/Outpatie		4 Nursing Home	5 Residence		cify)				
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_	Hospital 24 hours a Funerel E	ical Ce	(Check only 2 Medical Exami	sician: To the best of my k	nowledge, dea	ath occurred at the tim	e, date and place, an pinion, death occurred	d due to the cause I at the time, date	e(s) and manner a and place, and due	s stated. a to the cause(s)				
	To the P within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License			Date signed (Mont					
)	To To		200. Orginature and title of certifier	nl		0460			2/1-	7/04				
Λ	(1)		30. Name and address of person who co	ompleted cause of death ()	tem 23a) (Tvo		120			1- (,				
1	-(1)			Idlewild Ave	nue. E	aston. Mar	vland 2160	01						
	S	tate	31. Date filed (Month, Day, Year)	2. Registrar's Sig	nature	all I	y	•						
	Regis		FEB 2 0 2004	Blow A	F AGO									

		1	For State Registrar	State of Ma		partment of Fertificate of	lealth and M Death	ental Hygie Reg.	_ / H1Ha	07813
	Physicia		1. Decedent's Name (First, Middle, Las	_	. 1			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al			esch	4h City Tourn	r Location of Death	February	18, 2004 4c. County of Death	1438 M
	Examin	er	4a. Facility Name (If not institution, give	1 /		DXON	1 Hele		Prince (George's
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 8. Social Security	ex 7. Age	(In yrs. last birthda 66 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo July 12,	9. Birthp Cour 1937 IIIi	place (State or Foreign ntry) nois
	put	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			1	0d. Inside City Limits
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	h with the 23a or 28 st be not	al Director	10e. Street and Number 200 Careybrook Lai	ne		10f. Zip Code 207	45	10g	. Citizen of What Cour USA	itry?
36	be filed within 72 hours after death with the Maryland ital Hyglene. id other then "natural", or items 23a or 28a-f show event, the Musical Examiner must be natified.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	lo	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No	dispanic Origin? (Spe an, Mexican, Puerto I Specity:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	within 72 hou lene. than *natura	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5	+) 16a. De (Gi	. DO NOT use retire	during most of workii d)	ng	b. Kind of Business/In	dustry
121	filed with Hygiene. Sthar than		17. Father's Name (First, Middle, Last)	5+	Sys	tems Anal	VSt 18. Mother's Name		Computer iden Sumame)	
lanc	should be f nd Mental I marked ol matic eva	To Be	Alois		Resch		Rowena			Santa
lary	and and sm		19a. Informant's Name/Relationship (City or Town, State, Zip	Code)
	is 1 and 2 of Health itam 27 other tra		Mary M. Resch / W. 20a. Method of Disposition	ite	20b. Place of Dis	position (Name of			c. Location - City or To	own, State
mor	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif			rematory or other pla tion Ceme	tery 2/21/	'2004 C	linton, Ma	ryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Acer	900		22. Name and Addresses P. 6160 Oxon	ess of Facility Kalas Fur Hill Rd.,	eral Hom Oxon Hi	e, P.A. 11, MD 207	45
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do not ne.			r respiratory arrest	1,	Approximate Interval Between Onset and Death
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<u>,</u>	cate be executed obysician and the burial-transit	Examin	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
8760,	ate be shysicia the bur	licai		d						
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o u	ing Phys	ion: To	1 Pres 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	ry 28b. Tim	e of 28c. Inju	4 🗆 Nursing Ho	28d. Describe how		wist
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification;	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	e 290 Place of Ini	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number of Rura State) 200 C 12	al Route Number,
_	Hospital 24 hours (Funaral	edicaj C	29a. Certifier 1 Certifying PI	nysician: To the best miner: On the basis of and manner st	of my knowledge, defended of my knowledge of my knowledg	eath occurred at the t	ime, date and place, opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as s e and place, and due t	itated o the use(s)
4	To tha within 2 To tha comple	Med	29b. Signature and title of certifier	1 She	ty Do	29c. Licen	se number	290	1. Date signed (Month,	Day, Year) /9, 2004
_	(TO)		30. Name and address of person who	completed cause of d	death (Item 23a) (Ty	pe, Print) i fal Di	me, O	Ruba, P	MARYIBNO	1
	St Regist	ate rar	31. Date filed (Month, Day, Year) / FEB 2 0 2004		ar's Signature	and the same		0		

04-00999 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla - State 2-18-04 Registrar Amend #1.Per MEO PGC cr	and / De	partment of Health ar ertificate of Death	-	giene Reg. No. 2011	. 07814
54	Physicia		Decedent's Name (First, Middle, Last)		olden Rives	2. Date of De Month Februa	Day Yeer	3. Time of Death
•	/Medic Examin		4a. Facility Name (If not institution, give street and number) Fort Washington Hospital		4b. City, Town, or Location of C	Death	4c. County of Dea	th
1	Funeral Director		5. Social Security Number 6. Sex 1 Age (In y. 1 M 2 ☒ F 45	rs. last birthda Yrs.	Months Days Hours	Hrs. 8. Date of Bir Min. (Month, Da	th y, Year) 9. Bir Co	thplace (State or Foreign buntry) W York
	Maryland -f show	tor		City, Town or	Location hington			10d. Inside City Limits 1 X Yes 2 □ No
	with the	i Director	10e. Street and Number 11600 Olympic Drive		10f. Zip Code 20744		10g. Citizen of What Co USA	ountry?
200	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturelt, or Items 23s or 28s-f show aumatic event. Ite Madical Exacultur count be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2 Married	1 U.S. 1	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F □ Yes 2 ☒No Specify:	n? (Specify Yes or No Puerto Rican, etc.)	Black, Whit	
500-6171	within 72 hou ene. than "nature he Modical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Gi	cedent's Usual Occupation ive kind of work done during most o a. DO NOT use retired) Accountant	f working	16b. Kind of Business Trucking	•
	uld be filed Aental Hygie rked other tic event.	To Be Co	17. Father's Name (First, Middle, Last) Willie L. Golden III		18. Mother's	Name (First, Middle Johnson		
	12 ad		19a. Informant's Name/Relationship (Type, Print) Julia Johnson/Mother	11	ailing Address (Street and Number of 6 35 155th St. N		434	
aitimore,	0 0 == =		1 X Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	cemetery, c	sposition (Name of crematory or other place) ection Cemetery 2	2/12/04	Clinton,	MD
pail	permit. Pag Department Importent: I any injury o once.		21. Signalize of Funeral Service Licensee)	22. Name and Address of Facility 6500 Allentown F			
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	/Medical Examiner		Due to (or as a cons	sequence of):	,		U	
'n	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last Due to (or as a cons					
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T VITE	vysicien: Th iis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Xyes 2 No Hospital: 1 Inpatient 2	≥ X ER/Outpa	Other	f Death <i>(Check only o</i>	one) dence 6 □Other (Spe	cify)
DIVISION OF	Attending Physicien: r death. ector: Atter this certitics by the funeral director, I	Certification:	27. Manner of Death 1 □ Natural 5 □ Pending 2 ☑ Accident investigation 3 □ Suicide 6 □ Could not be	Formal	y Work? 1□Yes 2XNc	, Thejer		•
Ž O	Dir.		4 Homicide determined building, etc. (Sp.	ho	~~	City or To	ington, My	of your Brive
	To the Hospitel within 24 hours a To the Funeral E completely tilled	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my 2 ☐ Medical Examiner: On the basis of exam and manner states.					
^	To the within 2.	Σ	29b. Signature and title of certifier Thereby M. Kind		O.C.M.E	-	29d. Date signed <i>(Moni</i> February 05	
0	- (1)		30. Name and address of person who completed cause of death (Item 23a) (Typ	pe, Print) 111 Penn Street	, Baltimo	re, Marylan	d 21201
	Sta Registr		31. Date filed (Month, Day, Year) FFR 1 8 2004	gnature			_	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 () 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** М REEDY February EILEEN CAROLYN 21 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S LANHAM DOCTORS COMMUNITY HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days JULY 1947 WASHINGTON, DC Director 56 577-76-7733 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 X Yes 2 No Director PRINCE GEORGE'S UPPER MARLBORO MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 310 RIDGELY COURT 20774 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Hygiene. College (1-4or 5+) Flementary/Secondary (0-12) 4 yrs MATH TEACHER GOVERNMENT and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EARL MONROE THOMAS SR. **ELLA** Μ. TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at Important; if item 27 is eny injury or other trau MICHELLE L. BRADLEY/DAUGHTER 6062 CLERKENWELL COURT BURKE, VIRGINIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 2-27-2004 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final smllere **Physician** resulting in death) /Medical Due to (or as a consequence of) THROMBO CYTOPONEIC PURPURA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ SUNDRONE 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Pulmon ARY FIBROSIS 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After 1 Natural 2 Accident 5 Pending 1 Tyes 2 No investigation death. pletely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D35947 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) putchell ville Res. 20721 10274 LARCE MASON WAY \$ 202 G. Mckoyans 31. Date filed (Month, Day, Year) FEB 2 4 2004 32. Registrar's Signature State doorte Registrar

State of Maryland / Department of Health and Mental Hygiene Rag. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 22,2004 1748 Richard Christian Shockley /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M 2 □ F July 31,1943 Maryland 60 Director 214-42-8092 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at 1 XYes 2 ☐ No Director Goldsboro Maryland Caroline 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 21636 310 Railroad Ave Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. t □Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Transportation 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Howard R. Shockley Dorothy Gottwals 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21636 PO Box 47 Goldsboro, MD Emily Shockley spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/26/2004 Greensboro, Maryland Greensboro Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home PA PO Box 160 Greensboro, Mary 23a Part1. Enfer the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PO Box 160 Greensboro, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** carolia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed d (Omyopa) Due to (or as a consequence of): burial-1 Box 68760. thet use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No ŏ 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1⊠Yes 2□No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No 24a. Was an Jas autopsy certificate ha performed? OPF 1 Yes 30 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1/2 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. injury at Work? Certification: After 142 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident neral Director: / 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire TO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D0059762 21601 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) taido 219 S. Washington St Easton,Md 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 EB 2 9 Registrar

Shockley

Richard

			For State Registrar	State of	Maryland	l / Depa <i>Cer</i>	artment <i>tificate</i>	of Health of Death	and M	ental Hyg e	giene 2004	07818
		- 44	1. Decedent's Name (First, Middle, L	,						2. Date of Dea Month	th Day Yeer	3. Time of Death
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	Examin		4a. Fecility Name (If not institution, g			· CEN		Town, or Location			4c. County of Deet	
					7. Age (In yrs. Ia		If Under			8. Date of Birtl	Baltimore 9. Birth	City pplace (State or Foreign untry)
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-	D.		Usual Residence of Decedent		140-00	¥						10d. Inside City Limits
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	the M	Directo	Maryland Frederi	.ck	Fre	ederio	10f. Zip	Code			IOg. Citizen of What Co	untry?
	as or		7206 East Sundo	wn Court				21702)		United Sta	tes
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow to M. oleal Ex. nither must be notified at	Funeral	11. Marital Status		dent Ever in U.S	13. 1	Was Decedi	ent of Hispanic On the Cuban, Mexical	rigin? (Spe	cify Yes or No-		ican Indian,
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ם	ould be filed within 72 hours after death with the Marylan Mental Hygiene. arked other than "natural", or items 23a or 28a-f show artic event. The Macinal Examiner must be notified at	Bec	17. Father's Name (First, Middle, La	st)				18. Moth	ner's Name	(First, Middle,	Maiden Surname)	
Maryland 21215-0036	2 should be filed vand Mental Hygie vand Mental Hygie van marked other traumatic event. IL	2	Christopher Mi		sse						Schairer	
Mar	d 2 sh h and h and 7 ls m traum		19a. Informant's Name/Relationship								r, City or Town, State, 2	
စ်	Heall Heall tem 2		Debra S. Ousse,	grandmoti	ner 20b. Pla	ace of Dispo metery, crer	EBSE sition (Nam	Sundown	Court	Fred	rick, MD 20c. Location - City or	217()2 Fown, State
ē	Pages ent of nt: If I		1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control C		state	01ive	t Cem	eterv	2/23/	04	Frederick,	Maryland
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		ler	Sequentially list conditions, if any, leading to immediate		or as a conseque		2101	(1202)	//4 == /	1011/6		
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8760	icate be executed physician and s the burial-transit	dical		d								
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	1		30. Name and address of person wh	a completed course	e of death (Item		Drint)			0 -		
	/		NADEEM HASHM				ATO LO	gy, un	nmc	, 15 AL.	TIMORE .	
	Sta Regist		31. Date filed (Month, Day, Year)	9 2004 D	egistrar's Signati		dood	V				

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	3		Decedent's Name (First, Middle, La	ist)					2	. Date of Dea	th		3. Time o	of Death
ty d	Physici		Patricia Ann Sorr	entino					F	Month ebruar	у ^{Дау}	2004	5:45	АМ
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and numb	өг)	4t	. City, Town, or	Location o				nty of Death		
			Doctors Hospital				Lanham				Princ	ce Geo	rge's	
	Funeral		,	Sex 7. 1 ☐ M 2123(F	Age (In yrs. last birth	M	Under 1 Year onths Days	If Under :	Min.	. Date of Birth (Month, Day,	, Year)	9. Birth	place (State ntry)	or Foreign
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	or 28g	Director	10e. Street and Number			1	Of. Zip Code			1	0g. Citizen o	of What Cou	ntry?	
	th wit		5615 Annapolis Ro	ad			20710				Unite	ed Sta	tes	
' 0	e filed within 72 hours after death with the Maryland if Hygiene. other than "natural", or Items 23a or 28a-f show vent, the Medical Examination in the collined at	Funeral	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decede Armed Force 1 \(\text{Yes} \) 22	es?	13. Was	Decedent of His s, specify Cuban	panic Orig I, Mexican	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	14. R B	lace - Americ lack, White,		
21215-0036	iral', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date	os:	1 🗆	Yes 2X No	Specify:			Spec	cify: Whit	:e	
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	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner: On the basis and manner	est of my knowledge, of examination and/ stated.	death occ or investi	curred at the time gation, in my opi	n, date and nion, deat	d place, and h occurred	due to the ca at the time, da	use(s) and nate and place	nanner as st a, and due to	ated. the cause(s	s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Shafer, Sr. John Atlee February 13, 5:50 P 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4019 A Burkittsville Road Knovwilla

Physician

/Medical

Examiner

			1019 II Bulk.	+	Road				TITE	0411			Freger	
п	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. I		If Under Months	Days	If Under Hours	Min.	8. Date of B	av Year	9. 8	irthplace (State or Foreign Country) Iaryland
.26	Director		220-26-6066	X		87 Yrs.					June 7,	1916	IV.	laryLand
	pu s		Usual Residence of Decedent 10a, State 10b, Count	v	10c Cib	, Town or Lo	ocation							10d. Inside City Limits
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	or 2	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What C	Country?
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36	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show oldel Examiner must be notified at	by Fi	1 Never Married 2 Ma	If Yes, G	XX No ive		1□ Yes ¼		Specify:				Specify: W	hite
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Baltimore, Maryland	permit. Pages i Department of I Important: If its any injury or ot once.		21. Signature of Filmeral Service	Licensee	11	22	2. Name and	d Addres	s of Facilit	y Sta	auffer	Fun	eral Ho	mes, P.A.
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			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the death	. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between
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Division	or A of A Direction by	Certification;	4 Homicide determ	nined 289. Flaci	e of Injury · At holing, etc. (Specify	me, iarm, str	eet, ractory,	опісе		2	City or To			ural Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Med	29b. Signature and title of certific		ner stated.		200	License	number			304 D-	to signed /44	th Day Voor!
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	6		30. Name and address of person						_					/
	V		Austin A. Pea	rre, M.D.	300 Wes	t Nint	h Str	eet,	Fre	deri	ck, MD	2170	01	

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 07821 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death February Po, 2004 **Physician** Diana Lee Stiles 2:30 p.[™] /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2FXF 219-52-2250 54 Director 1950 January 10, Maryland Usual Residence of Decedent with the Maryland or than "natural", or Items 23a or 28a-f ahow The Medical Examiner must be notified at 10a State 10b County 10c, City, Town or Location 10d. Inside City Limits Frederick Maryland Brunswick tx□Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 3rd Avenue Completed by Funeral U.S.A. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☼ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Importent: If Item 27 is marked other ti amy injury or other traumatic avent, IIIs QIDEB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Thomas Janet Biddinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Wineberg Court, Woodsboro, Maryland Ed Fogle - Son 21798 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 2/18/2004 14 □ Donation 5 □ Other (Specify) Frederick Crematory Frederick, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Karon Cerrue 1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** Cance /Medical Due to (or se a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the original Cause (Disease or injury that initiated events resulting in death) Last as a considence of). Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, the attending physician for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 TNo 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Ē 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death investigation 1 Yes 2 No 2 Accident filled in by the within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) the and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address person who completed cause of death (Item 23a) Date filed (Month: Day, Year) ENHO 32. Rec State FEB 1 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 () L Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Month BERNARD STEER ALBERT 10:40PM February 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Hospital Prince Georges Lanham | Months | Days | Hours | Min. | Month, Day, Year) | Min. | April 10,1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 096-30-0333 84 Yrs Director Panama Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show the Medical Exeminar must be notified at XXYes 2 □ No Prince Georges Maryland Directo Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 12403 Starlight Lane 20715 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ∏Yes 2√ No fYes, Give Λ Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 Yes 2 No White Specify: δ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than. Coltege (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Haalth and Mental Hygient Importent: If item 27 is marked other the any injury or other treumatic event. In 2006. Accountant Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert Agustus Steer Mary Isabel Rance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leticia Steer/ Wife 12403 Starlight Lane, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gate of Heaven 2/23/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** PUMONIA doys /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ate has been signed by the atten page 2 should be detached for u 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 13 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 No rs after deau...
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in by the funeral director, pe 10 CXTION 1 Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗍 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of pers who impleted cause of death (Item 23a) (Type, Print) Wille Rd. B216 Bayes, MO2016 Muam Lusaya, mo 40002 32. Agistrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 9 2004 Registrar

			For State Registrar	State	of Marylar		artment of H		Mental Hyg		004	07823
, Di	43	(la)	1. Decedent's Name (First, Middle	le, Last)					2. Date of Deat Month	th Day	Year	3. Time of Death
	hysicia /Medic	al .	Mary Virgin					1	Februar		2004 ty of Death	9:20 P M
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30 St.		100	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr	rs. 8. Date of Birth			nce (State or Foreign
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lanyla	and all	ō										1X Yes 2 □ No
the N	Dolling.	rect	MD Princ 10e. Street and Number	e Georges		Hyatts	10f. Zip Code		1	0g. Citizen o	f What Count	ry?
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death	E DIE	Funeral Director	11. Marital Status	12 Was De	cedent Ever in L	J.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No- erto Rican, etc.)		ace - America lack, White, e	
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Val	T IS T		19a. Informant's Name/Relation: Rose Marie A1		htor				Rural Route Number ace APT#54			
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ages ent of	y or c		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (5		n State		matory or other place ematory		/18/2004	Wald	dorf, M	m l
Definition (e.), Mary Jania 4.14.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	injur		21. Signature of Funeral Service			- T	2. Name and Addre		Robert E.			
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the death cert	been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of pregn birth 2 Fet gnant at time of known	al death 3	□Ectopic pregnancy □ Other (specify) _	' N/	A		Date of deliver Month [y Day Year
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To the within 2	To the	Me	29b. Signature and title of certific	er /			29c. Licens	e number	2	9d. Date sign	ned (Month, D	Pay, Year)
			* Kaman	1. (uli'		019	609.	0	2.17-	04.	
			30. Name and address of person 3503 PEA	RRY ST	REET	mor	Print) RAI	MAN,	Ring To	7/2	H(1)	
. 2	Sta Registi		31. Date filed (Month, Day, Yea.	9 2004	. Redistrar's Sign	nature /	food					

			1 - For State of Maryland / Depa	rtment of Health and M tificate of Death	lental Hyg	giene 2 (004	07	824
	Dhysiai	20	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ath Day	Year	3. Time of	Death
	Physicia /Medic		Dorothy Butler Sandleman		Februar		004	1:55	P M
	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County		1	
			Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Annapolis If Under 1 Year If Under 24 Hrs.	8. Date of Birtl	Anne A			r Foreign
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	P _		Usual Residence of Decedent						
	show	7	10a. State 10b. County 10c. City, Town or Loc	ation			10	0d. Inside Cit	
	Ba-f	ecto	Maryland Anne Arundel Annapolis 10e. Street and Number	10f. Zip Code		10g. Citizen of W	/hat Caus		- 25,10
	with a or 3		2576 Twin Landing Cove	21401		United S		*	
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9	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28a-f show for Medicul Exertings for itedified at	F	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No	Yes, specify Cuban, Mexican, Puerto i □ Yes 2⊠ No <i>Specify:</i>	Rican, etc.)		k, White, e		
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/lar	uld be Wenta Wenta urked	ToB	Howard S. Butler	Beulah Yu	ıl e				
Maryland	2 sho and is ma			Address (Street and Number or Rura					0.1
e) S	1 and lealth om 27 ther to		20a. Method of Disposition 20b. Place of Disposi	Win Landing Cove	Annapo	20c. Location -			01
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Ever it intermst be notified at once.		1 Burial 2 MCremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore	atory or other place)		Bal timor	•		.d
Balt	permit. Departimport. any inj		SOM 1 1 / 1 / 1	Name and Address of Facility Joh 7 Duke of Glouces	n M. Ta	ylor Fu	neral	Home	-
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Division of Vital Records,	ding P. h. After funer	tion	27. Manner of Death 1	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28Q. Describe n	ow injury occurre	d		
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	Vithin Fo th	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed	(Month, D	ay, Year)	
)			For Pelen mo	024804		2-1	8-2	004	
			30. Name and address of person who completed cause of death (Item 23a) (Type, P	7,2001 Medical	Parkway			1401	
	Sta Registr		31. Date filed (Month, Day, Year) 2004 32. Registrar's Signature			7,000	1 5	- 1-1	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** Masdelen Chran 10 204.4 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Medica of Maryland Maryland Universit-If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□ M 2风F Yrs. Director 220-32-9401 68 6,1935 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Directo Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24861 Hema 23a Lamsmeadow Road 21678 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2月2 No Specify: If Yes, Give Specify: 3 Widowed 4 Drvorced Year or Dates: "naturel", **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other then "any injury or other traumatic event, tra MesonGe. Elementary/Secondary (0-12) College (1-4or 5+) 11 Line worker Campbell Soup 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 James E. Wilson Mable Hynson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilson Illinois Ave., Severn, Maryland 21144 Larry / son 1431 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-14-2004 Butlertown, Maryland Mt.Olive Cemetery 22. Name and Address of Facility
Bennie Smith Funeral Home
Road 298, Chestertown, Maryland 21620 21. Signature of Fune(al Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Scleroderma renal **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner levodermo Sequentially list conditions, I my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 🗆 Probably 4 💆 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 □ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Ceath 1 Natural filled in by the funeral s after death. ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	arylan	d / Depa	artment of H	lealth and Death	Mental Hy	giene Reg. No.	2004	07826
			1. Decedent's Name (First, Middle,	Last)					2. Date of De	aath Day	Year	3. Time of Death
	Physici /Medio		CHRISTINE	SCARBOROUGH	[Februa			12:45 A M
Ĵ.	Examir		4a. Facility Name (If not institution, g	rive street and number)			4b. City, Town, or	Location of Dea	th	4c. (County of Death	
			CORSICA HIL			DER	CENTREV	ILLE If Under 24 Hrs	1 a m : (5:		UEEN AN	
	Funeral		,	1 M 2 F		last birthday) Yrs.	If Under 1 Year Months Days	Hours Min	. (Month, Da	nth ay, Year)	Cour	* *
	Director		219-14-3999 Usual Residence of Decedent		32				Aug.18	,1921	Virg	inia
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show r must be notified at	ţō	Maryland Queen A	nnec		entrev	1110					1 A Yes 2 □ No
	r 28s	Director	10e. Street and Number	intes		entrev	10f. Zip Code			10g. Citiz	en of What Cour	ntry?
	h wit	a D	205 Armstrong A	ve.			21617			USA		
	dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (i	Specify Yes or No rto Rican, etc.)	0- 1	 Race - Americ Black, White, 	
õ	or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 😿		1	1 ☐ Yes 2 1 No	Specify:			Specify:	
0000	within 72 hours after death with the Marylan idea. Jenes 23a or 28a-1 show the Macified at the Medical Examiner must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:		1 100 D				10h Kin		ack
	nat	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	tent's Usual Occupa kind of work done of DO NOT use retired	durina most of wo	orking	160. Kin	d of Business/In	dustry
V	filed within Hygiene. ther then int, the Me	m d	Elementary/Secondary (0-12) Unk.	College (1-4or	5+)	Clam	Shucker	,		Soaf	ood Pla	n t
7 0	Hygint, Int.	e C	17. Father's Name (First, Middle, La	st)		OLam	Silucker	18. Mother's Na	me (First, Middle			
Jand	d be ental	00	IIIem					Pear1	Dwarm			
<u></u>	s 1 and 2 should f Health and Mer item 27 is marke other treumatic	2	Ukn. 19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a		Brown		Town, State, Zip	Code)
Ž	alth ar 27 is r treu		Ronald Brown /	Grandson		110	Kennedy	Dr. Che	estertow	n Mar	vland 2	1620
a)	item other		20a. Method of Disposition		20b. F	lace of Dispo	sition (Name of natory or other place		Date		ation - City or To	
Бапппо	00-		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Cemeter	· 1	14-2004	Hi11	sboro.Ma	arvland
	mit. Pag partment cortant; I injury o		21. Signature Funeral Service Lie		, ,		Name and Addres Bennie S					,
ă	Departi Departi Importa eny inj		Mylust	all)	_		Road 298	mith Fur Cheste	neral Ho ertown.M	me arvla	nd 2162	0
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	the deat	h. Do not ent						Approximate Interval Between
	Physician		Immediate Cause (Final	1 1.C.	N. 12	11111	celar 10	1100080	24			Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as								
	Examiner		Constable list and bings	b								
		ner	Sequentially list conditions, if any, leading to immediate cause.	Due to (or as	a conseq	uence of):						
	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
/60,	e exe ien a urial-	E	resulting in death) cast	Due to (or as	a conseq	uence of):						
200	physic physic the b	dical		d				·				
o X	death certificate e attending physical for use as the	Physiclan/Med	IF FEMALE:	23c. If yes, outcome	of pregna	nov					Date of delice	
X O Z	attendattende	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Feta	Ideath 3□	Ectopic pregnancy Other (specify)			2.	3d. Date of delive Month	Day Year
		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	t time or a	oatii 5	Cities (specify)					
7.	requires that the de- peen signed by the a hould be detached f		Part II. Other significant condition	s contributing to death b	ut not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	lobacco us	e contribute to the	ne cause of death?
g.	sign d be	d by	Pu kun on A						1 🗆	Yes 2É	3 □ Prob	ably 4 Unknown
coras	beer shou	Completed	Coronay Greethol	A 100 4 8	130	10			24a. Was	20	24h Were auto	psy findings available
d)	e la has	E D	COLCUMA	17000	10.	esar	2.		auto		prior to condeath?	mpletion of cause of
	ician: Th certificate rector, pag			OGGT HY.	100	2 676 30	LL C		1 Yes	202 No	1 🗆 Yes	2 □ No
VITA		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		5D/0	Othe		ath <i>(Ch</i> eck only Home 5 ☐ Resi		Поль	
ō	Phys rthis ral di	—	27. Manner of Death			ER/Outpatien			28d. Describe			/)
	ding h. Afte tune	ton	1 Avatural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju (Month, Da	y Year)	Injury		<br Yes 2 □No		. ,		
DIVISION	To the Hospitel or Attending Pr within 24 hours after death. To the Funerel Director: Alter it completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could no	be 28e. Place of In	ury - At ho	ome, farm, str	eet, factory, office				Number or Rura	I Route Number,
2	after Dire	erti	4 Homicide	building, et	c. (Specif	y)			City or To	wn, State)		
	spite ours nerel			Physician: To the best								
	e Ho e Fui letely	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner st		tion and/or in	vestigation, in my of	pinion, death occ	urred at the time,	date and	place, and due to	the cause(s)
	vithir To th	M	29b. Signature and tiple of certifier				29c. License				signed (Month,	
	,- ,,, ,		\$ 9.11 lun	No.			DYZ	295		02/	12/200	9
			30. Name and address of person wi	no completed cause of o	leath (Iten	п 23а) (Туре,	Print)					
			Eric Hermanse	en,M.D	2108	Didor	ato Dr.,	Chester	.Marvlar	d 216	619	
	Sta	ate				ture			,			
	Regist	rar	FEB 18	2004 32. Registr	1	Ac	di					
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DHMH 17 Rev 1/2001

		1 - For State Registrar		State of M	laryland / D	epa Cer	rtment of I	lealth and	d Mental H	ygien Reg. N	-	07827
Dhysia	20	Decedent's Nam							2. Date of D		ay Year	3. Time of Death
Physici /Medi		Margare	t Page	Shortal1	·				Feb	18	2004	12:55 PM
Examir	ıer	4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of De	eath	40	c. County of Dea	
				Care - T	ne Pines	3		ston			Tal	bot
Funeral		5. Social Security N		5. Sex 7. A 1 ☐ M 2 ☐ √F	ge (In yrs. last birth		If Under 1 Year Months Days		in. 8. Date of E	lirth Day, Year	9. Bi	rthplace (State or Foreign country)
Director		219-14-		X	79 ^Y	rs.			9-24-			DE.
pug *		Usual Residence o	10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City, Town	or Loc	cation					10d. Inside City Limits
faryli sho	ö	MD	Talbo	L								1 X Yes 2 □ No
ith the Maryland or 28a-f show	Director	10e. Street and Nu			st. M	1C	naels 10f. Zip Code			10- 0	Maria - 4 14 ft - 4 60	
with	급						Tot. Zip Code				itizen of What C	ountry?
72 hours after death with the Maryland neturel', or Items 23e or 28e-f show areal Examiner must be notified at	Funeral	109 Mi	les Lai	12. Was Deceden	t Ever in II S	12 14	21663	diamania Osigin?	(Choothy Von as A		SA_ 14. Race - Am	origan ladian
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irs aft	by F	3 ₩idowed	_	d 1 □Yes 2√2 If Yes, Give ↑ Year or Dates		1	☐ Yes 🏋 No	Specify:			Specify: Wh	ite
thours		X	15. Decedent's			Deced	ent's Usual Occup	ation		16b. 6	Cind of Business	
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within liene.	Completed	Elementary/Second 11 yea:		College (1-4or				,		Wh	aaton	Tubing
2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	Be C	17. Father's Name	(First, Middle, La	ist)	r d C	CLC	ory Wor	18. Mother's N	lame (First, Middl			тивтид
Mental arked o	To B	Oscar I	Harrisc	n Page				Ethol	May Ba	11		
should nd Men marke imaric	-	19a. Informant's N			19b.	Mailin	g Address (Street		Rural Route Num		or Town, State.	Zip Code)
ith a		William	a a1									
permit. Pages 1 and 2 should b Department of Health and Ments Important: If tiem 27 is merked any injury or other traumatic e <u>once.</u>		4 ☐ Donation 21. Signature of Ft	☐ Cremation 3 5 ☐ Other (Spe uneral Service Li	DEPROMENTAL PROMESTATE CONTROL OF TH	Tilghn	nan 22. R	Cemete Name and Addre	ery 2-1 ess of acility oll Huj	21-04 clev Fu	 Tilo nera	ghman,i	MD PC
		23a. Part1. Enter t	he disease, or co	omplications that cause	d the death. Do no	ot ente	r the mode of dying	x 518 3 ng, such as card	St Mich	aels	, MD.2	oximate
Pnysician		Immediate Cause	(Final	nly one cause on each	line.							Interval Between Onset and Death
/Medical	0.0	disease or condition resulting in death)	on	a. Due to (or a	s a consequence of	127C						days
Examiner				dehu	doctor		and la	1.0010	10min			dans
	Je.	Sequential y list co if any, leading to in cause. Enter Under Cause (Disease or	inditions, nmediate	Due to (or as	a consequence of):	arial Vi	4/200	lemia			auy5
ste be executed lysician and he burial-transit	Ical Examiner	Cause (Disease or that initiated events resulting in death)	5	c	strutic s a consequence of		avuno	ma-u	incirta.	in f	Dring	ing months
artifica ing pt	Med	IF FEMALE:										-
The law requires that the death certificate tte has been signed by the attending physbage 2 should be detached for use as the	Completed by Physiclan/Mec	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months? ⊒No		e of pregnancy 2 Fetel death at time of death		Ectopic pregnancy Other (specify) _	/			23d. Date of de Month	livery Day Year
res that the igned by be detact	Y P	Part II. Other signif	ficant condition	s contributing to death	but not resulting in t	the un	derlying cause giv	en in Part I.	23e. Díd	tobacco	use contribute to	the cause of death?
uires sign d be	q p	athera	scleros	is, coven	ans dis	Sea	50		10	Yes 2	□No 3□P	robably 4 ☑ Unknown
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elav has je 2 g	пр	nypert	ension	' / ' ' '	neval !	1/11	so-dell lure	sive	24a. Wa:		prior to	utopsy findings available completion of cause of
	ပ္ပ	disease	, Lett	ventric	ular to	all	ure		1 ☐ Yes	2/X No	death? 1 ☐ Yes	2 □ No
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Physic this c	၉	1 ☐ Yes 2 🔀			ent 2 ☐ ER/Outp		3□ DOA Oth	er: 4 A ursing	Home 5 ☐ Res			cify)
ding P h. After I funera	on:	27. Manner of Deat	h 5 🗌 Pending	28a. Date of Inj (Month, Da	ury 28b. Tir ay Year) 28b. Tir Inji	me of ury	28c. Injur Wor		28d. Describe	how inju	ry occurred	
Attending Physician: r death. sctor: After this certifics by the funeral director.	catl	2 Accident	investigat	t be				Yes 2 ☐ No				
or Att	Certification:	3 Suicide 4 Homicide	determine	286. Place of In	jury - At home, farn tc. (Specify)	n, stre	et, factory, office		28f. Location City or To	(Street an wn, State	d Number or Ri	ural Route Number,
Hospitel 4 hours a Funerel I	Medical Cer	29a. Certifier (Check only one)	1 ★ Certifying 2 Medical Ex	Physicien: To the best eminer: On the basis of and manner s	of examination and/	death or inve	occurred at the tir estigation, in my o	ne, date and pla pinion, death oc	ce, and due to the	cause(s)) and manner as d place, and due	s stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and	title of certifier				29c. Licens	e number		29d. Da	te signed (Mont	h, Day, Year)
->-0		A800	main	n ND			DE	7860		Celsi	rans 1	8,2004
			JIV LE VI	, , , , ,			20	7000				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

State Registrar

31. Date filed (Month Day, Year)

DHMH 17 Rev 1/2001

Margaret Shortall

21601

Avenue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 10 February rucilla Reatrice :MPSON 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENERAL 6. Sex CAMBRIDGE

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. HOSPITAL DORCHESTER DORCHESTER 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F 215-26-264 Usual Residence of Decedent Director Jan. 8, 1930 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be modified at 1 Yes 2 No Completed by Funeral Director Dorchester ambridge filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1613 USA Avenue 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□ Yes 212 No Specify: Black 3 12 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Production-Line Worker Seafood Company 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event <u>QICE</u>. 17. Father's Name (First, Middle, Last) Be Edward Cornish Annie Dickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tom, State, Zip Code) 4151. Gilkey Lane Hopkinsville 20a. Method of Disposition 20c. Location - City or Toylin, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State ucktown Cemetery 2/21/04 Bucktown, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part Enter the disease, or complications that caused the dead, Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intextina Infarction Pnysician Vays /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any secting to impose access. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Registrar

29b. Signature and title of certifier /

31. Date filed (Month, Day FEB 17

st. Cambridge,

who completed cause of death (Item 23a) (Type, Print)

00

20034 Registr

		1 - For State Registrar	State of Maryland	/ Depa		Health and	Mental Hy	giene	2001	. 07829
Physici /Medic Examin	al	Decedent's Name (First, Middle, Last Walter Car 4a. Fecility Name (If not institution, give	l Siebert		4b. City, Town, o	or Location of Deat	2. Date of Dea Month Februar	y 18	Yeer 3, 2004 County of Deatl	3. Time of Death 6:00 a.m.
Funeral Director		19671 Piney Poi 5. Social Security Number 216-09-9499 Usual Residence of Decedent		st birthday) Yrs.	If Under 1 Year Months Days	Valley Le	8. Date of Birth	h v. Year)	Co	cy's hplece (State or Foreign untry) yland
death with the Maryland ms 23a or 28a-f show must be matified at	Director	10a. State 10b. County Maryland St. Mar 10e. Street and Number		Town or Lo	Valley	y Lee		10a. Citiz	en of What Co	10d. Inside City Limits 1 ☐ Yes 2 🖥 No
be filed within 72 hours after death with the Marylan last Hygiene. Ad other than "natural", or thems 23a or 28a-f show svent, the Medical Examiner must be marified at	by Funeral Di	19671 Piney Point 11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ■Yes 2 □ No 1941 If Yes, Give		20	0692 Hispanic Origin? (S an, Mexican, Puer Specify:		Uni	ted Sta 4. Race - Ame Black, White Specify: Whi	ncan Indian, o, etc.
d within 72 hour jiene.	Completed t	15. Decedent's Ed. (Specify only highest grad	cation	(Give life. L	DO NOT use retire	during most of wo.		16b. Kin	d of Business/I	industry
should nd Mer merk matic	To Be C	17. Father's Name (First, Middle, Last) Walter Henry Sieb 19a. Informant's Name/Relationship (Ty				18. Mother's Nar	me (First, Middle, Pauline D	Maiden S ebus	Su <i>mam</i> e)	
permit. Pages 1 and 2 v Department of Health ar Important: If item 27 is any injury or other trau once.		Jacqueline Rosend 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Septice (Specify)	20b. Pla cen	4257 ce of Disponentery, crem	Derby Wheation (Name of place of the place o	narf Driv	e, Virgi	nia 20c. Loc Char	Beach, ation - City or 1	VA 23456 Town, State Hall, MD
Physician /Medical		7/11/10/11.15	, / /	Do not ente	2955 Holl or the mode of dyir	Lywood Ko	ad, Leon	ardt	eral Ho	ome, P.A. 20650-0279 Approximate Interval Between Onset and Death Marths
eath certificate be executed at attending physicien and for use as the buriat-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence)	0	Asto	ry L	Seast			
The law requires that the death certificative has been signed by the attending phage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal di 4 □ Pregnant at time of deal 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)	/		23	d. Date of delive	very Day Year
w requires that the death been signed by the atte should be detached for	þ	Part II. Other significant conditions con	ntributing to death but not resulti	ing in the un	derlying cause giv	en in Part I.	23e. Did to	\ \		the cause of death?
	e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was a autops perform 1 Yes	ned? 28 No		opsy findings available ompletion of cause of
ng Phy ther this	Certification: To B	examiner? 1	lospital: 1 Inpatient 2 EF 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hombuilding, etc. (Specify)	8b. Time of Injury	28c. Injur Wor M 1 □	er: 4 Nursing H	ome 5 Reside 28d. Describe ho	ence 6	occurred	rfy) al Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funetal Director: A completely filled in by the fo	Medical Ce	one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	estigation, in my o	pinion, death occu	rred at the time, d	ate and p	lace, and due t	to the cause(s)
2 3 2 3			mpleted cause of death (Item 2	3a) (Type, F	29c. Licens	o number 00 5798 - Lookout			signed (Winth,	/ /
Sta Registr		SARA L. HORTO	N MD 25 2004 ² . Registrar's Signatur	* 1	Point	lookout	Kaad	Lear	nasd bu	n Marcoso

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Somervi David 0154 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County Columbia Howard General Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Securify Number 6 Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Hours 1 MM 2 □ F 216-40-6913 Director 64 1939 Apr.8. Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show sny injury or other traumatic event the 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22374 Three Notch Road Funerai 20653 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ■ No 1 ☐ Yes 2 E No Specify: þ If Yes, Give Year or Dates: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personnel Specialist US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Dellie Somerville Susie Frederick ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) California, Maryland 20619 Grace C. Somerville / Wife P.O. Box 234, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) 1-10-2004 Lexington Park, MD Immaculate Heart 22 Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funera Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 3 Probably 4 Unknown 1 Tyes 2 No Be Completed Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an tor: After this certificate has I the funeral director, page 2 s 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 Homicide ö within 24 hours a To the Funeral I 1 E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) 29c. License number MO

1000

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) FEB 0 2 2004

Carmen Salvat

M.D. 3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of M	Marylan	id / Depa <i>Cei</i>	artmer <i>rtificat</i>	nt of H e of L	ealth a Death	and M	ental Hy	giene Reg. No	200	4 0	783
	Division		1. Decedent's Name (First, Middle, La	st)							2. Date of De	ath Da	y Yea		me of Death
	Physici /Medic		Robert Curtiss S	naffer							7 \	ary	19, 201	14	55 PM
	Examin	er	4a. Facility Name (If not institution, giv						Location	of Death		1	County of De		
			Washington Count			last birthday)	_	rsto 1 Year	WII If Under	24 Hrs.	8. Date of Bir		ashing		itate or Foreign
	Funeral Director			1 ⊠ M 2□F	69	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Date) 1/07/1	935) 5. 2	Country)	MD
			Usual Residence of Decedent				1								
	arylan show	_	10a. State 10b. County			ty, Town or Lo									ide City Limits]Yes 2 ☐ No
	8a-1	cto	MD Washing	ton	_ Ha	gersto						10. 0			7163 2 100
	with the	宣	10e. Street and Number 855 Dewey Avenue				10f. Zip	21742				US	tizen of What (Δ	Jountry ?	
	ns 23	Funeral Director	11. Marital Status	12. Was Deceder		.S. 13.	Was Dece	dent of Hi	spanic Ori	igin? (Spec	cify Yes or No		14. Race - An	nericen Indi	an,
	r Iten	듄	1 Never Married 2 Married	Armed Forces		1	If Yes, spe	cify Cuba	n, Mexicar	n, Puerto F	Rican, etc.)		Black, Wh		
	ral', o	l by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates	i:		1 □ Yes	2 X No	Specify:				Specify: W	nite	
ה ה	72 h	Completed	15. Decedent's E (Specify only highest gra			16a. Dece	dent's Usu kind of wo	al Occupa	ation during mos	t of workin	19	16b. K	(ind of Busines	s/Industry	
7	han han	μ	Elementary/Secondary (0-12)	College (1-4o	r 5+)		chini)			М	lanufac	turino	or .
7	Hygie ther t		17. Father's Name (First, Middle, Last)		Tic	CILLIII	.50	18. Mothe	er's Name	(First, Middle	1		curing	5
2	d be enta! ked o	To Be	Curtis Alfred Sh	affer					De1	lla (1	nmn) K	enda	.11		
<u></u>	2 should and Mile mari	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	s (Street a	and Numbe	er or Aural	Route Numb	er, City	or Town, State	, Zip Code)	
Z	alth a alth a 27 le		Linda Homza (Dau	ghter)		PO B	ox 77	5 Bar	tonsy	ville	, PA 1	8321			
5	of He of He roth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Demoval from Star	20b. F	Place of Dispo cometery, crea	sition (Name	me of other plac	Θ)	Da	ate	20c. L	ocation - City o	or Town, Sta	ate
altillion	Pag ment ant: I ury o		'4 □Donation 5 □Other (Special		Smi	ithsbur	g Cr	emato	or. c)2/23			thsburg		
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 le marked other than "natural", or items 23a or 28a-f show important: If item 27 le marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Mardical Exp. time round by notified at ance.		21. Signature of Funeral Service Lice	1599	>										al Home
_	0 □ ≒ a 0	_	23a. Pert1. Enter the disease, or com	***	2								town, l		ximate
	Physician Medical	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a Due to (or a Due to (or a d.	e conseq) MC Squence of):	VIA	\							and Death
O. Box 68	the death certifi y the attending ched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fete	el déath 3	□Ectopic p □ Other (sa						23d. Date of d Month	elivery Day	Year
T	law requires that as been signed b 2 should be deta	by Pi	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying o	ause give	en in Part I		23e. Did t	obacco	use contribute	to the caus	e of death?
Records	w require been sig should b	Pa	CUNG CA	WCER	<u> </u>						1 🗆	Yes 2	□No 3□I	Probably	4 Unknown
ည္က	aw re	ompieted									24a. Was		24b. Were	autopsy find	tings available n of cause of
	The I	E O									perfo	rmed?	death	s 2 No	
Z	sician: The law s certificate has t lirector, page 2 s	BeC	25. Was case referred to medical examiner?							of Death	(Check only	one)			
5	Physician: this certific ral director,	P	1 ☐ Yes 2 ☐ No			ER/Outpatier			4 🗆 140				6 ☐Other (Sp	ecify)	
	ding Phys h. After this funeral di	on:	27. Manner of Death 1. Dending		Day Year)	28b. Time o Injury	f M	28c. Injury Work	rat ⟨? Yes 2		8d. Describe	how inju	ry occurred		
UIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined.	28e. Place of I	Injury - At he etc. (Specif	ome, farm, str fy)			163 20		8f. Location (City or To		nd Number or i	Rural Route	Number,
	ne Hospita 7 24 hours ne Funeral detely filled	edical C	29a. Certifier (Check only one) Certifying Place Certifying Place	hysicien: To the bes miner: On the basis and manner	st of my kno of examina stated.	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, a	nd due to the d at the time,	cause(s date and) and manner d place, and d	as stated. ue to the ca	use(s)
	To the To the Comp	ž	29b. Signature and title of certifier	7	_		29	c. License	number			29d. Da	ite signed (Mo	nth, Day, Ye	ear)
			1/6				L	30	55	794		2/	20/0	4	
			30. Name and address of person who			n 23a) (Type.	Print) C	154	14100	JNK	30THA	n	7		
			11110 Me OICAC		strar's Signa	# /	43	1+/-	tire	CON	Marc				
	Sta		31. Date filed (Month, Day Year)	1004	Suar Solgha	A. A.	ad all s	g.							

			For State Registrar	State of M	laryland		rtment of F	lealth and N Death		iene 19. No. 20	n.	በ7ልጓን
			Decedent's Name (First, Middle, Last)	1					2. Date of Deat	h	V	3. Time of Death
п	Physicia		Travis Lee Yate	s. Senio	r				Month February	Day 21	2001	1047 AM
?	/Medic Examin	_	4a. Fecility Name (If not institution, give				4b. City, Town, o	r Location of Death	J	4c. County	of Death	
			Washington County	Hospita	1		Hager			Wash	ingtor	
	Funeral Director		5. Social Security Number 6. Se 214-28-2207 12	7. A]M 2□F	ge (In yrs. Ia 73	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Feb. 12,		9. Birthpla Counti Maryla	
	pu ,		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	cation				10	d. Inside City Limits
	Maryla f show	ior	Maryland Washingt	on	, oo. ony,		gerstown					1 ☐ Yes 2 🙀 No
	with the tale or 28e-	Direct	10e. Street and Number 19119 Poffenberge	r Road			10f. Zip Code 217	40		nited		•
9	hours after death with the Maryland tural; or Itema 23a or 28e-f show al Examinations! be notified at	/ Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceden Armed Forces 1√ Yes 2 ☐ If Yes, Give	? 105	-	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	tc.
9	n 72 hours "natural", udical Exe	ted by	34 Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates	195	16a. Deced	lent's Usuat Occup	ation during most of work	ring	16b. Kind of B	44117	
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Maryland 2	be filed Ital Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last) James R. Yat	es					e (First, Middle, M		ne)	
Ž	\$ DEE	ř	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailir	g Address (Street	and Number or Ru	ral Route Number	City or Town,	State, Zip (Code)
	nd 2 lith a 27 is		Travis Yates, Jr.		son	19119	Poffenb	erger Roa	d, Hager	stown,	Mary]	and 21740
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,		Ce	metery, crer.	sition (Name of natory or other place n Mem. Pa	ark 2-24		agerst		m, State faryland
Balti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licens	_				ss of FacilityMin				and 21740
8760,	Physician /Medical Examiner	icai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last	Due to (or a	s a consequence s a consequenc		leros.	is	Infan	etin	7 1	Interval Batween Onset and Death MMULACT
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Division	or Attendater death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I building,	njury - At hor etc. (Specify,	ne, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Numl n, State)	ber or Rural	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a Certifier Certifying Ph (Check only one)		of examinati							
)	To the within To the	Me	29b. Signature and title of certifier	Marcas	11		29c. Licens			9d. Date signs		
54	x. dx1		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print) Wii	115/100	of Ha	(POS)	town	3 2004 mb 217
	Sta Regist	ate rar	31. Date fited (Month: Pan Year)	004 32. Hegis	strar's Signat		weeker		,			2

		1	For State Registrar	State of Maryla		artment rtificate				Re	g. No.	2004		7833
A A.	Physicia	ın	Decedent's Name (First, Middle, Last) NELLIE CATHERINE							. Date of Deat Month bruary	Day		3. Tim	e of Death
	/Medic	al -	4a. Facility Name (If not institution, give			4b. City, T	own, or	Location of		Druce		County of Deat		<u> </u>
	LAdillill	25.4 25.4	RAVENWOOD LUTHERN			HAGI			4 Hrs. a	Date of Birdh	WA	ASHINGT		to or Forning
	Funeral		5. Social Security Number 6. Security Number 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	7. Age (In yr.	rs. last birthday) Yrs.	If Under 1 Months	Days	Hours	Min.	Date of Birth (Month, Day, SEPT • 2	6 · 1	13	untry) MARYL	te or Foreign AND
1-31	Director		Usual Residence of Decedent										10d foeid	e City Limits
	show	5	10a. State 10b. County	INGTON	City, Town or Lo		нась	ERSTOW	JN					Yes 2 No
	the M	Directo	MARYLAND WASH	INGION		10f. Zip (10101	***	1	0g. Citi:	zen of What Co	untry?	
	h with 23a or		1183 LUTHER DRIV	₹				1740				U.S		
20	should be filed within 72 hours after death with the Maryland and Mental Hygiene. merked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show maric event, If a Medical Examinar must be notified.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 🕅 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13.	Was Decede If Yes, speci 1 \(\text{Yes} \) 2		spanic Orig n, Mexican, Specify:	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)		14. Race - Ame Black, White Specify:		n,
5-0036	thour		15. Decedent's Edu	ıcation	16a. Dece	dent's Usual	Occupa	ition	of working	7	16b. Ki	nd of Business/		
212	within 72 ene. than "na!	Completed	(Specify only highest grad	Coflege (1-4or 5+)	life.	REGIS	e retired,)			(COUNTY H	IOSPT'	ΓΑΤ.
N	filed wi Hygien other th	Co	17. Father's Name (First, Middle, Last)	3		KEG15	TEKI			First, Middle,			1001 1.	
and	ould be filed with Menfat Hygiene arked other tha atic event, If a	To Be	CHARLES C. MARTI	N				CARR	IE A.	LUNG				
Maryland	2 2 3 3		19a. Informant's Name/Relationship (T									r Town, State, 2 , MARYL		21742
re,	of Health of Health if item 27 or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	200	o. Place of Disp cemetery, cre	matory or ot	her placi	θ)	Da			cation - City or		
Baltimore,	t. Pages rtment of rtant: If it njury or o		* 4 □ Donation _5 □ Other (Specify) DE	AVER CR							ERSTOWN NATIONAI		
Balt	permit. Departr Importa any inj			eimen	_	BAST I	UNE	RAL H	OME	BOONSB	ORO,	, MARYL	AND :	21713
	*		23a. Part1. Enter the disease, or composhock, or heart failure. List only of	one cause on each line.		nter the mode	of dying	g, such as	cardiac or	respiratory arr	est,		Approx Interva Onset	imate I Between and Death
	Physician /Medical		fmmediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	erl fer	leve							70	laup
180	Examiner		O wastella lisa acaditicas	r Ceripl	ienal	vooc	ele	w	lese	ease			54	ears.
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O. Box	0 0 0	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	Fetal death 3	☐Ectopic pro						Month	Day	Year
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Division	Die te	Certification:	3 Suicide 6 Could not be determined	28e. Pface of Injury - A building, etc. (Sp	At home, farm, soecify)	street, factory	, office		2	28f. Location (S City or Tox	Street ar vn. State	nd Number or F e)	lu <i>ral R</i> oute	Number,
	Hospita 4 hours Funeral ely filled	edical C	29a. Certifier 16 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, de mination and/or	ath occurred investigation	at the tir	me, date an opinion, dea	nd place, a oth occurre	and due to the ed at the time,	cause(s date an	and manner a d place, and du	s stated. e to the ca	use(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier			290	c. Licens	se number			29d. Da	ate signed (Mon	th, Day, Ye	ar)
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	HIS		30. Name and address of Person who	completed cause of death	(Item 23a) (Typ	e, Print)	rel-	140	ugen	stour	101	17 C	40.	
C	S	tate	31. Date filed (Month, Day Year) 9	32. Registrar's S	Signature	Sperke	1							

SEWARD, nellie catherine

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MARY ALICE BUTTS SINES 2255 PM 2004 etmany /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON Months Days Hours Min. Month Days Hours Min. JULY 12, 1941 Birthplece (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕅 F MARYLAND 218-40-3992 62 Yrs Director Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ? is marked other than "natural", or Itams 23e or 28a-f show traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No MARYLAND WASHINGTON HAGERSTOWN Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 141 EAST AVENUE 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) CASHIER DRUG STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi NORMAN HARRISON EDLEBLUTE SADIE MAE KLINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVIS M. BEAN, DAUGHTER 143 EAST AVENUE, HAGERSTOWN, MARYLAND 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State BOONSBORO CEMETERY 2/20/2004 BOONSBORO, MARYLAND * 4 □Donation 5 □Other (Specify) 21. Signature of Foneral Service Licensee 7606 OLD NATIONAL PIKE BAST FUNERAL HOME 16119 A. Zimmerman BOUNSBURG, MARYLAND 21713 23a. Part1. Enthy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronain 3 HRS appr Physician /Medical Due to (or as a consequence of): Examiner Distase ivenery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-transit Millie Daster Y EARLS Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 NNo
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 AUnknown Be Completed Vos Chila 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? (es 2 No page 2 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 1 ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident the 1 Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospital of within 24 hours at To the Funeral D 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 46561 Ladu/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CADIR HAGDESTOWN GITAZIALA 1190 MT HETNA 31. Date filed (Month, Day, Year) FEB 19 32. #egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Mary	yland / Depa <i>Cei</i>	artment of Hertificate of D		neg. It	e2004	
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Nellie Marie S 4a. Facility Name (If not institution, give s Washington Cou	treet and number)	al	4b. City, Town, or	Mo Fe to	ruary	Year 17 200 c. County of Dee Washingt	th
e.	Funeral Director		5. Social Security Number 6. Sex 217-32-6241	7. Age (II	n yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days		te of Birth onth, Day, Yea	_	thplace (State or Foreign ountry) aryland
	death with the Maryland ims 23s or 28s-f show	ector	Usual Residence of Decedent 10a. State 10b. County PA Franklin 10e. Street and Number	10	Oc. City, Town or La	Chambersbu	ırg	10-0		10d. Inside City Limits 1 ☐ Yes 3☐ No
	s 23s or	Funeral Director	3414 Guildford S	pring Rd.	v in 11 S 12 3		7201-8852		U.S.A.	•
9-00-6	72 hours after d natural', or Item dical Examinari	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		f Yes, specify Cubar	spanic Origin? (Specify Yen, Mexican, Puerto Rican, Specify:	etc.)	Black, Whit	
7-61717	s 1 and 2 should be filed within 72 hours after death with the Marylan if Heelth and Mental Hygiene it Heelth and Mental Hygiene it Heelth and Mental Hygiene it I have seen than "natural," or flems 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa' kind of work done di DO NOT use retired) Homemaker	uring most of working	16b.	Kind of Business	•
	should be filed ind Mental Hygi marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Lewis Preston Wil	es			18. Mother's Name (First, Anna Paul			
33	s 1 and 2 sho of Heelth and Item 27 is my other traumy		19a. Informant's Name/Relationship (Ty) Ralph M. Shelly 20a. Method of Disposition	(Husband)		Guildford	nd Number or Rural Route Spring Rd. Date	Chambe		PA 17201-885
Dallimor	it. Page nument o nument: iff njury or		1 Bunsl 2 Cremation 3 R Donation 5 Other (Specify) 21. Signature of Funoral Service Licentee	emoval from State	Smithsbu	natory or other place ing Cremat . Name and Address	Feb. 1	8, 04 Sm	ithsburg	g,Md.
	Physician /Medical Examiner		23a Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the e cause on each line. Typic Due to (or as a co	e death. Do not entr		Smi	thsburg	,Md. 217	
,0070	death certificate be executed e attending physicien and of for use as the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	3c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
COLUS, T	The law requires that the ste has been signed by th page 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but no	0	1	ating 23	e. Did tobacco		the cause of death?
		Completed	Hyperten	Sion			···	a. Was an autopsy performed? Yes 2 N	prior to death?	topsy findings available completion of cause of 2 No
VICA	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpatien		26. Place of Death (Chec			
	and free	—	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injury Work?	* 4 Nursing Home 5 at 28d. De	scribe how inju		cny)
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	l Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	Specify)		Cit	y or Town, Sta	te)	Iral Route Number,
	the Hosin 24 hosin 24 hosin 24 hosin 100 hosin	ledical	29a. Certifier (Check only one) 2 Medical Examin	ician: To the best of m ier: On the basis of exa and manner stated	amination and/or inv	estigation, in my opi	e, date and place, and due nion, death occurred at th	to the cause(: e time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To To To To H	2	29b. Signature and title of sertifier	- N	ND		number 057537	29d. D.	ate signed (Monti	h, Day, Year)
	Sta	ate	30. Name and address of person who co	mpleted cause of death	ye MD	124 N V	valout St	Ha	gershw.	MD 21740
	Regist		FEB 19 200	4 Barre	M. Ass	uki				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4:44 AM FEBRUARI 15 2004 EUGENE ALBERT STOTTLEMYER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
MARCH 11, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 XI M 2 □ F 217-32-6065 1936 67 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7830 OLD NATIONAL PIKE 21713 <u>U.S.A.</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No 1958— If Yes, Give Year or Dates: 1960 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 CUSTODIAN PUBLIC SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) PAUL STOTTLEMYER LENA BEAKLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VEGENIA A. STOTTLEMYER/SPOUSE 7830 OLD NATIONAL PIKE, BOONSBORO, MARYLAND 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 □ Donation 5 Other (Specify) BOONSBORO CEMETERY 2/18/2004 BOONSBORO, MARYLAND 21. Signature of Figheral/Service Licensee 22. Name and Address of Facility 7606 Old National Pike Man Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part1. Enter the disea or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Solar on men disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bue to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 25 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No 1 patient Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of De 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 2 🗌 No investigation 1 Tyes 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40627 person who completed cause of death (Item 23a) (Type, Print)/ StoMORDINVIKU PK. 32. **oistrar's Signature 31. Date filed (Month Day

The law requires that the death certificate be executed Division of Vital Records, P.O. Physician: or Attending

Box 68760

State Registrar

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Director

Funerai

Completed by

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Completed by Physician/Medical Examiner

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Certification: To

Medical

item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, it s Madical Examinal must be notified as

death with the Maryland

filed within 72 hours after

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within 24 hours after death To the Funeral Director:

H.yrl

attending physician

Baltimore, Maryland 21215-0036

marked

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician February 2004 6:22 P.M Bernard Carl Shupp /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown 18805 Eliason Way Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Pay Year) | Oct. 21, 1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1[XM 2□F Maryland 220-40-0164 Yrs Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Itam 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 18805 Eliason Way 21742 U.S.A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Maintenance Nursing Home permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Itam 27 is marked other this any injury or other traumatic event, that 2005. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret E. McCauley Carl W. Shupp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 18805 Eliason Way Hagerstown, Md. 21742 Joyce D. Shupp 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ☐Bucial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Feb. 15, 2004 Smithsburg, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility ice see 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Emis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical **Examiner** 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last the attending physician P.O. Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy 1 Live birth ō in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, funeral director, page 2 should be Kung 3 Probably 4 □Unknown Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Certification: To 3 DOA 4 ☐ Nursing Home 5 x Residence 6 ☐ Other (Specify) 2 FR/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 1🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Opal conf COR POUES JER 31. Date filed (Month, Day, Year) 32. Registrar's Signature 18 Registrar

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For	State of Maryland / Department of Health and Mental Hygiene $200l_{ m l}$

			For State Registrar	State of M	arylan	d / Depa <i>Cei</i>	artment o	of He	ealth a leath	nd Me		giene Reg. No.		40	7838
>	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last, MARY JOSEPHI 4a. Fecility Name (If not institution, give	NE SINC			4b. City, To]	2. Date of Dea Month Februa	Day 4c.	County of De	14 7 • 3 ath	e of Death
	Funeral Director		213-62-7586			ion Ce last birthday) Yrs.	tf Under 1 Y		rlin If Under 2 Hours	Min.	8. Date of Birt (Month, Day 9 / 13 / 1		Worces	inthplace (Sta	ite or Foreign
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Worcest	er]	y, Town or Lo Berlin	ocation								e City Limits
	with the	i Director	10e. Street and Number 320 Bay St.				10f. Zip Co	181	1				zen of What (Country?	
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at	d by Funerai	11. Maritat Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	•			t of Hisp Cuban,	panic Orig	in? (Spec Puerto P	rify Yes or No- lican, etc.)		14. Race - An Black, Wi		n,
Maryland 21215-0036	iled within 72 h lygiene. ther then "netu nt, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 5	cation e completed) College (1-4or	5+)	(Give life. l	dent's Usual C kind of work of DO NOT use r	lone du etired) ker	ring most		g (First, Middle,	C	ond of Busines Own Ho		
/lanc	should be f nd Mental h marked of umatic ava	To Be	Richard Frankli	n Harris							ebecca				
	i 1 and 2 sho Health and I tem 27 is mu		19a. Informant's Name/Relationship (T) Diana M. William: 20a. Method of Disposition		20b. P	320 Place of Dispo	Bay S	t. I	Berli			11	r Town, State		3
Baltimore,	Part and		1 XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)			ringhil	natory or other I Mem.	Ga	rden	S		Heb	oron,	MD	
Ball	permit. Pag Department Important: eny injury conce.		21. Signature of Angral Service Licent	where	11007	0/ 22	2. Name and A	ddress	of Facility	he E	Burbag lin, MI	e Fu	ineral	Home	
	Pnysician /Medical		23a. Perf. Enter the disease, or compl shock, or hear feiture. List only o Immediate Cause (Finat disease or condition resulting in death)	ne cause on wat I	ine. he	h. Do not ent		t dying,		ardiac or			.1011	Onset a	mate Between nd Death
8760,	Examiner	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as	onsequ	vence of):	9602								
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	Ectopic pregr					1	23d. Date of d Month	elivery Day	Year
٥.	w requires that is been signed by should be deta	by	Part II. Other significant conditions co	ntributing to death l	out not res	ulting in the u	nderlying caus	se given	in Part I.			obacco u 'es 2)	se contribute ŽNo 3⊟!		of death?
Vital Records,		Completed									1 Yes	sy med? 2∏ No			
fVit	Physician: this certific ral director.	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No	fospital:	ent 2	ER/Outpatien	nt 3 DOA	Other	11000		(Check only o		3 □Other (Sp	ecify)	
Division of	ding h. After fune	Certification:	27. Manner of Death 1 Avatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da		28b. Time of Injury	М		at es 2□N	lo	8d. Describe h				
DIX	tal or Attenders safter deati	Certifi	4 Homicide determined	28e. Place of In building, e	jury · At ho tc. <i>(Specif</i>)	ome, farm, str y)	eet, factory, o	ffice		2	Bf. Location (S City or Tou			Rural Route N	lumber,
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	edical	29a. Certifier 1 Certifying Phy (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best ner: On the basis of and manner si	of examina	wledge, deatl	h occurred at t vestigation, in	ne time my opir	, date and nion, deat	l place, ai h occurre	nd due to the d d at the time, d	cause(s) date and	and manner place, and de	as stated. ue to the caus	se(s)
	To the P	Me	29b. Signature and title of certifier	11.1			29c. L	icense i	number	9		29d. Dat	e signed (Mo	nth, Day, Yea	r)
\sim	11 >		30. Name and address of person who c	ompleted cause of	death (Item	n 23a) (Type,	Print)	0 C	09	Ce	us for	2 d	Hug	104	77111
	H, K	- 1	31. Date filed (Month, Day, Year) FEB 2 3 2	32. Régist	rar's Signa	iture	ي غذ غ	ces	esus		1560	-c/	11	2 / 9	744
	Registi	ar	LED 09 (004 Desc	W .	A. A.	MAGLI								

Sinclair, Mary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 2.2.2.

	1	For State Registrar		State of Ma	arylario	Cei	tificate of I	Death		Reg. No.	2004	0783
Physician /Medical	1.	Decedent's Name (ıgene	Sli	der		Sr.	2. Date of Dea Month FEBRUAR	Day	2004	3. Time of Death 0725 A M
Examiner Funeral Director	5.	MEMORIAL Social Security Num 218-16-4	HOSPITAL ober 6. Sex	7. Age	a (In yrs. Ia	st birthday) Yrs.	4b. City, Town, or CUMBERI If Under 1 Year Months Days	AND If Under 24 Hrs. Hours Min.		AL	LEGANY 9. Birth	
show ed all	-	Sual Residence of Dona. State 1	ob. County Allegan	v	10c. City,	Town or Lo	cation berland					10d. Inside City Limits
with the N la or 28a-1 Lee noulli I Direct	1	0e. Street and Numb					10f. Zip Code	21502		10g. Citizer	of What Cou	intry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If tiem 27 is marked other then "nature!, or itams 23e or 28e-f show or other traumatic event, the Medical Examination must be notified at or other traumatic event, the Medical Examination must be notified at or other traumatic event, the Medical Examination or other traumatic event, the Medical Examination or other traumatic event.	1	1. Marital Status 1 Never Married 3 Widowed 4	2 Married	2. Was Decedent I Armed Forces? 1 Ves 2 In If Yes, Give Year or Dates:		L.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		Rece - Amer Black, White Decify: wh	, etc.
unithin 72 hou piene. r then "nature the Medical E		(Specify Elementary/Second	5. Decedent's Educionly highest grade ary (0-12)	ation completed) College (1-4or 5	i+)	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor d)	rking		of Business/l	ndustry
2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Ita M. To Be Comp	1	7. Father's Name <i>(Fi</i> Freder	rst, Middle, Last) ick A. Slid	er					ne (First, Middle, M. (Grace			
1 and 2 should health and Nealth and Nealth and New 27 is mather traumanther t	-	19a. Informant's Nam Fanny SI		wife		125	ng Address (Street 508 Blue V	/alley Rd	SE Cum	berlan	nd M	ID 21502
permit. Pages 1 and Department of Health Important: If Item 27 eny Injury or other tr once.	2	0a. Method of Dispos 1 Durial 2 1 4 Donation 5	Cremation 3 Re	emoval from State	20b. Pla ce Sur	nce of Dispo metery, crer ISET ME	sition (Name of matory or other plac morial Park	ce)	2/16/2004		nberlar	
permit. Page Department of Important: If eny Injury or once.		21. Signature of Fune	mus 7	A up	ll	_ 1		ginia Avent	ue: Cumbe		MD 2150	
Control of the executed Physician and State Parial-transit as the burial-transit edical Examiner edical Examiner		23a. Part1. Enter the shock, of heart is shock, of heart immediate C use (Fidisease or condition resulting in death) Sequentially list cond fany, leading to immediate. Enter on Jeri, cause (Disease or in hat initiated events resulting in death) La	itions, ediate	RENAL F Due to (or as NEPHROS Due to (or as	AILUR a consequi CLERO a consequi	E ence of): SIS ence of):	or the mode of syn	g, 3001 23 021 03X				Approximate Interval Between Onset and Death 6 months
The law requires that the death certificate be execu- te has been signed by the attending physician and lage 2 should be detached for use as the buriat-train completed by Physician/Medical Exar		F FEMALE: 23b. Was decedent p in the past 12 m 1 Tes 2 Tes 9 Unknown	onths?	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	□Ectopic pregnancy □ Other <i>(specify)</i> _	/		230	d. Date of deli Month	very Day Year
equires that sen signed b nould be deta	1	Part II. Other signific CONGESTI	NE CARDIA	tributing to death b	ut not resu E	lting in the u	inderlying cause giv	en in Part I.				the cause of death?
	-	CORONARY	ARTERY 1	DISEASE					24a. Was autor perfo 1 - Yes	an 2 osy ormed? 2\int_No	death?	topsy findings availab completion of cause of 2 No
hysician: Th his certificate I director, pag To Be Co		25. Was case referre examiner? 1 ☐ Yes 2 ₺ N		ospital:	ent 2 🗆 8	R/Outpatie	nt 3 DOA Oth		ath (Check only o		Other (Spec	eify)
tending Plasth. tor: After the funeral		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	28a. Date of Inju (Month, Da 28e. Place of Injuding, et	y Year) jury - At ho	28b. Time of Injury me, farm, st	Wor	yat k? Yes 2∐No	28d. Describe I 28l. Location (: City or Tou	Street and N		ral Route Number,
Hospi 24 hou Funer Fely fill			Cartifying Phys		f examinati							
To the within 2 To the comple		29b. Signature and ti	N.H.	Conj. The			29c. Licens			29d. Date s	b 147	1. Day, Year)
nd State		30. Name and address N.A. RANJ 31. Date filed (Month	ITHAN, M.	D. 517 C	DLDTO	IN ROA		RLAND, MD	21502			

State of Maryland / Department of Health and Mental Hygiene 2004 07840 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Eleanor Stewart FEBRUARY 15, 2004 2245 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F 90 02/07/1914 West <u>Virginia</u> 213-40-4164 Director Usuel Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show Examiner count be notified at 1 Yes 2 □ No Cumberland MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 12 Crescent Place or Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturat", or item any injury or other traumatic event, the Medical Examene Black, White, etc. 1 ☐ Yes 2 🕅 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: f Yes, Give Year or Dates: Specify: 3 N Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clifford Kent Mahalia Elizabeth Roderick Thomas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 760 Hunt Terrace, Cumberland, MD JoAnn E. Harper / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tXXBurial 2 ☐ Cremation 3 ☐ Removal Irom State 02/19/2004 Green Hill Cemetery Williamsport, WV 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Faneral Service Licenses 21502 404 Decatur Street, Cumberland, MD che 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) 1 WEEK **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Day Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be CORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: rector. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To luneral dir 28c. Injury at Work? 28a. Dale of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural Injury 5 Pending 1 Yes 2 No investigation within 24 hours after death. To the Funeral Director: 2 Accident the f 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide the Hospital to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier FEBRUARY / D33280 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) カメ 625 KENT AVENUE, SUITE 101, CUMBERLAND, MARYLAND 21502 SUNIL K. GUPTA, M.D., 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

		1	For State Registrar	. 1040	State	of Mar	yland	-			ealth ai Death	nd Me	ental Hyg	jiene	20) 4	07	841
	Physicia /Medica	n	1. Decedent's Name Fernando										2. Date of Dea Month 2-12-04		y Y	er	3. Time of 4:4!	Death P.M
	Examine	-	4a. Facility Name (If Holy Cro						Silv	er Sp	_			M	County of	mery		
	Funeral Director		5. Social Security No.	79	.Sex 1⊠XM 2⊡F		76	Yrs.		Days	If Under 24 Hours	Min.	B. Date of Birtl (Month, Day 6-29-2	, Year) 7	9	Birthpla Countr E1 S	ice (State o y) alvad	or Foreign
	show		Usual Residence of 10a. State MD	10b. County Montgot	mo r sy	1		Town or Lo		·						10	d. Inside C	ity Limits 2☑ No
	with the A a or 28a-i Lbe notifi	<u> </u>	10e. Street and Nun 4506 Ga	nber			DIT	VET D	10f. Zi	p Code 0906				10g. Cit	izen of Wha	t Counti	ry?	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merital Hygiene tem 27 is marked other than "neturel", or iteme 23a or 28a-f show other traumatic event, it a Medical Examiner must be rutified at	급	11. Marital Status 1 Never Marrie 3 Widowed	ed 2⊡xMarne	12. Was D Armed 1 1 Ye If Yes.	ecedent Event Forces? Is 251No Give r Dates:	er in U.S.	1		edent of Hi ecify Cuba	Specify:		ify Yes or No- ican, etc.)		14. Race -	White, e		
1215-00	within 72 houseners she "neture	Completed by	(Speci		grade complete	ed) e (1-4or 5+)			dent's Usu kind of w DO NOT o		ation during most (ind of Busin	ess/Indi	ustry	
o G	uld be fited Mental Hygiurked other itic event, I	To Be Co	17. Father's Name (Jorge Ga	(First, Middle, La	ist)				iiwasi	ici			(First, Middle, Salina	Maiden				
Fennando Saltimore, Maryland	and 2 sho leath and A m 27 is ma her trauma		Jackie A	rias -		ughte		4506	Gayı	nor R	d. Si		Route Numbe Spring	, M		06	-	
timore	permit. Pages 1 Department of H Important: If ite any injury or of once.		20a. Method of Disp 1 StBurial 2 [1 Donation 21. Signature of Fu	☐ Cremation 3 5 ☐ Other (Spe	cify)	om State		te of Disponentery, createry, ea	ven	2	-17-		Si1	ver S	prin)	
B	perm Depa Impo any i		23a. Part1. Enter ti	un C	ozpel	cvat caused th	ne death.	1	1800	New	Hamps	hire	Ave.,	S11		prin	Approxima	9
760,	ysicia ysicia ne bur	ical Ex	Immediate Cause (disease or condition resulting in death) Sequentially list condition if any, leading to improve cause. Enter Under Cause (Disease or that initiated events resulting in death) if	nditions, nmediate orlying is	a. Re Due Ex Due c.	espira to (or as a c cacerb to (or as a c	tory conseque atio	nce of): n of nce of):									Onset and	Death
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	w requires that been signed b should be deta	٥	Part II. Other signif	ficant condition enal fa		o death but	not result	ting in the u	inderlying	cause give	en in Part I.				use contribe			
of Vital Records,	sician: The law requ certificate has been irector, page 2 should	Completed	Ischem	ic cardi	onyopat	thy							24a. Was autop perfor 1 🗆 Yes	sy rmed?	prio	re autop r to com th? Yes	sy findings ipletion of a 2 No	available ause of
Vita	ician: certific ector	o Be (25. Was case referexaminer?		Hospital:	⊠ Inpatient	2∏E	B/Outnatie	nt 3 🗆 🗆	Oth	ac.		(Check only o		6 DOther	(Specify)	
ion of	fing After	- 1	27. Manner of Deat 1 Natural 2 Accident	th 5 🗌 Pending investiga	28a. Da (A	ate of Injury Month, Day		28b. Time o Injury		28c. Injun Worl		2	8d. Describe h					
Division	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 4 Homicide	6 Could no determin	led 289. P	lace of Injunuilding, etc.							8f. Location (S City or Tox	vn, Stati	9)			ber,
	the Hospital or , hin 24 hours after the Euneral Dire plately filled in the plately fill	edical	29a. Certifier (Check only one)	1 ☑ Certifying 2 ☐ Medicel E	Physicien: To xeminer: On th and n	the best of ne basis of e nanner state	xaminatio	ledge, dea on and/or in	vestigatio	n, in my o	pinion, deatl	d place, a h occurre	d at the time,	date an	d place, and	due to	the cause(s)
	To the I	Ř	29b. Signature and	Dan	D.	le	ay to	D	ul	9c. Licenson	e number 2261				12-04	Month, E	Jay, Year)	.,
	,		30. Name and addi				1			g, MD	2090	6						
	Sta Registra		31. Date filed (Mor	th, Day, Year) EB 1 7	2004	2. Registrar				ocks			-					

		•	1- State of Maryland / Department of Health a Certificate of Death	and Mental Hygie	/ Η Η Η Α ΤΩ Ι. 1
	Physicia	an	1. Decedent's Name (First, Middle, Last) ERIC WARREN SELLERS	2. Date of Death FEBRUARY	Day 2004 3. Time of Death
7	/Medic Examin		4a. Facility Name (If not institution, give street and number) N.I.H. 4b. City, Town, or Location of Bethesda	f Death	4c. County of Death Montgomery
H	Funeral Director		5. Social Security Number 127-60-7805 6. Sex 1 Months 127 Months Days Hours	Min. 8. Date of Birth (Month, Day, Ye April 26,	9. Birthplace (State or Foreign Country) 1976 New York
	Maryland -f show	tor	Usual Residence of Decedent		10d. Inside City Limits 1 ሺ¥yes 2 ☐ No
	h with the 13a or 28a st be nuti	al Direc	10e. Street and Number 7111 Woodmont Ave., Apt # 310 10f. Zip Code 14221	10g.	Citizen of What Country? U.S.A.
396	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heatilt and Mental Hygiene. The filem 27 is anxied to ther than "natural", or items 23a or 28a-f show item 27 is anxied to the rithen "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be redified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, Give 1 Yes, Give 2 Year or Dates: 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican 1 Yes, Give 1 Yes 2 No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 hou ene. than "natura in Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	t of working	b. Kind of Business/Industry
and 21	ould be filed w Mental Hygier arked other thatic event, in	To Be Col	17. Father's Name (First, Middle, Last) Ronald Sellers Fe	rs Name (First, Middle, Mai rn J. Reichar	
, Mary	1 and 2 should be Health and Mental em 27 Is marked other traumatic ev		19a. Informant's Name/Relationship (Type, Print) Ronald Sellers / father 19b. Mailing Address (Street and Number 38 Birchwood Dr.,		
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or other			eb. 20,2004 T	
B alt	permit. Depart Import any inj		Mullar 121 ~ 254 Carroll St.	, NW. Washir	Mebrew Funeral Home, Ington, D.C. 20012
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause of each line. Immediate Cause (Finat disease or condition resulting in death) a. Due to (gr as a consequence of):	cardiac or respiratory arrest,	July, 2000
		ilcal Examiner	L d		Dec, 2003
.O. Box 6	ne death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. tf yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	v requires that the bean signed by should be detact	þ	Part II. Other significent conditions controuting to death but not resulting in the underlying cause given in Fart.	23e. Did tobac	co use contribute to the cause of death?
Vital Records,		Completed		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ō	ding Physician: Th n. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1	of Death <i>(Check only one)</i> Irsing Home 5 Residence 28d. Describe how	
Division	or Attendent firer deatl Sirector: in by the	Certification:	1 Naturat 5 Pending (Month, Day Yeer) Injury Work? 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 3 Yes 4 Yes 5 Yes 5 Yes 5 Yes 6		it and Number or Rural Route Number, itate)
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce		d place, and due to the caus th occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
•	To the villain to the comp	Me	29b. Signature and title of centifier DO 041B	33 (State) 29d.	Date signed (Month, Day, Year)
	•		30. Name and address of person who completed cause of death (trem 25a) (Type, Print) 10 CENTER DRIVE, BI 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ETHESDA, MD	20892
	Sta Regist	ate rar	FED 9 0 2001 Remove By Market		

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			= State Registrar					Ce	rtificat	e of l	Deatl	h		Reg. No	. 201	J 4	0784	3
	Physicia /Medic		1. Decedent's Name (First, Marbara Ficke			k							2. Date of De Month Februa	Da	4, 200	ear)4	3. Time of Death 4:25pm ^M	
	Examin		4a. Facility Name (If not instit	ution, give	street an	d number)			4b. City,	Town, or	r Location	n of Death			c. County of			
		4	Wilson Healtl					1 6 int d- 1		hers		er 24 Hrs.	2 Date of B		ontgo			
	Funeral Director		5. Social Security Number 201–18–4337		X □M 2⊠		80 (In yrs.	last birthday) Yrs.	Months		Hours		8. Date of Bi (Month, D July 2	3, Year	923 P	Coun	ace (State or Foreign try) ylvania	,
	and and	}	Usual Residence of Decedent 10a. State 10b. Co.				10c. Cit	y, Town or Lo	ocation				· · · · · · · · · · · · · · · · · · ·			1	Od. Inside City Limits	
:	Mary Fied	to	Maryland Mon	ntgom	erv		Ga:	ithers	burg								1⊠Yes 2□No	
	or 28s	Director	10e. Street and Number						10f. Zip	Code				10g. C	itizen of Wha	at Coun	try?	
	23a	rai	301 Russe11	Avenu						877					ted S			
	items items	Funerai	11. Marital Status 1 Never Married 2	Marriad	Ame	Decedent of Forces?		.S. 13.	Was Dece If Yes, spe	dent of H cify Cuba	ispanic C in, Mexic	an, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black,			
0000	lrs aft	by F	3 ☐ Widowed 4 ☑ Divo		If Ye	s, Give	••		1 🗆 Yes	2 [] No	Specif	y:			Specify:	Whi	te	
5	2 hou	ted	15. Dece (Specify only h	edent's Ed	ucation	ated)		16a. Dece	dent's Usu	al Occup	ation	nst of work	ina	16b. I	Kind of Busin	ess/Ind	lustry	_
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	8		30. Name and address of pe	rson who	completed	d cause of o	leath (Iter	m 23a) (Type	, Print)									
			Lee Jonathan		ner,				consi	in Av	enue	e, Ch	evy Cha	se,	MD 20	815		
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 14 07866 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month February 15 2004 4:30 A M Alice Ludeman Spencer 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 13508 Sherwood Forest Terrace Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) Feb. 25 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 ☑ F 95 219-64-0406 Feb. 1908 Kansas Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Maryland Silver Spring Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20904 U.S.A. 13508 Sherwood Forest Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Marned 1 ☐ Yes 2X No 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Economist U.S. Dept./Agriculture 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) A. M. Ludeman Frances Mae Walters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald A. Spencer - husband 13508 Sherwood Forest Terrace, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Crematory 2-17-2004 4 Donation 5 Other (Specify) Brentwood, Maryland Ft. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Av., Silver Spring, MD 20904 23a. Fart1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aortic Stenosis years disease or condition resulting in death) Due to (or as a consequence of) Coronary Artery Disease years Sequentially list conditions, Due to (or as a consequence of) if any, leading to intrinductor cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 __ fnpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 XNatural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner The law requires that the death certificate be executed burial-transit Box 68760, attending physician use as the for ed by the a Division of Vital Records, P.O. page 2 should be certificate has Physician: funeral director, this After or Attending the

Physician

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is 1 and 2 should be filed within 72 hours eiter death with the Marylan if Health and Mental Hyglene. Item 72 is marked other than "neturel", or Items 23a or 28a-f ehow other traumatic event, the Madical Examinist must be notified at

Baltimore, Maryland 21215-0036

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Examiner Physician/Medical á Completed Be Certification: To after death. filled in by Hospitel within 24 hours a completely e g

> State Registrar

Medical

31. Date filed (Month Yeer)

4 | Homicide

(Check only one)

29b. Signature and title of

30. Name and address of persper

D. Leonard Griffen III, M.D. 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

and manner stated

15225 Shady Grove Road #201, Rockville, MD 20850 anks

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D42110

29d. Date signed (Month, Day, Year)

February 17, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

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	Physicia		1. Decodert's Name (1 1131, 10100	_{le, Last)} Glen Spai					2. Date of Dea Month Februar	Day Yea Y 16, 2004	
	/Medic Examin		4a. Facility Name (If not institution 328 Soapstone		mber)			or Location of Deat	h	4c. County of De	ath
2225	Funeral Director		5. Social Security Number 212-11-8070	6. Sex 1	7. Age (In yrs. I 18	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9. 8 1985 Ma	irthplace (State or Foreign Country) ryland
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ate has page 2	e Completed	25. Was case referred to medical					26 Place	_	4a. Was an autopsy performed ☐ Yes 2 🔀	17	prior to com leath?	sy findings availa apletion of cause 2 No
fter this	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	be 29a Blace of Join	y 28b. Ti	me of jury M	28c. Injury Work 1 🗆 Y	or: 4 □ Nurs	sing Home \$ 28d. D	Residence	injury occurr	ed	Route Number.
within z4 nours arer dearn. To the Funeral Director: A completely filled in by the fu	edical Certii	29a. Certifier (Check only one) 29a. Certifier (Check only one)	Physician: To the best of aminer: On the basis of	of my knowledge.	death occurre	d at the tim	e, date and inion, death	place, and di	ity or Town, S	tate)	oner as sta	tad
To the	Med	29b. Signature and title of certifier	and manner sta	MD	2	9c. License	number 67c	4	29d. Fe	Date signed	(Month, D	ithe cause(s) ay, Year) By ARRY
Stat Registra		30. Name and address of person when the control of	KANKONI	eath (Item 23a) (T	Type, Print) THER	Pl	ERMA	tne n	1TE 1	LA	RG-0	, MARY

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment or artificate	of Healt <i>of Dea</i>	th and M ath		iene 200	4 07848
			Decedent's Name (First, Middle, Last,)					2. Date of Deat	th	3. Time of Death
	Physici /Medic		Henry Clay Saylo	r, III					Month February	Day Yee y 25, 2004	214
1	Examin		4a. Fecility Name (If not institution, give			4b. City, To	wn, or Locati	tion of Death		4c. County of D	
			Montgomery Hospice	- Casey	House	Rockv				Montgome	ry
	Funeral		5. Social Security Number 6. Sec	x 7. Ag M 2 ☐ F	e (In yrs. last birthday)	If Under 1 Months [Year If Un Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		579 20 5235	JW ZUF	79 Yrs.				August 2	3,1924 Was	shington, DC
	pur *		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation					10d. Inside City Limits
	lanyli eho	ō			Charry Ch						1 ☐ Yes 2√∑ No
	28a-1	ect	Maryland Montgome 10e. Street and Number	Ly	Chevy Ch	10f. Zip C	ode		1	0g. Citizen of What	Country?
	with March		3509 Preston Cour	+				20815		USA	
	within 72 hours after death with the Maryland ene. than 'natural', or Itema 23e or 28e-f ehow Ita Madiçal Examirer musi be nutified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Deceder			cify Yes or No- Rican, etc.)	14. Race - A	merican Indian,
(O	or Iter	F	1 ☐ Never Married 2 🖾 Married	Armed Forces? 1 XYes 2 □	No WWII,				Rican, etc.)	Black, W	hite, etc.
ğ	ral', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Korea	1 Yes 2	ăNo Spe	cny.		Specify:	White
2	natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece (Give	dent's Usual (Occupation done during	most of worki	ng	16b. Kind of Busine	ss/Industry
7	ithin)du	Elementary/Secondary (0-12)	College (1-4or	5+)						
7	ygier ygier her th		A7 Salada Nasa (Circle Middle Jose)	5+	Direc	tor, R				<u>Telephone</u> Maiden Sumame)	Company
and	be fill	Be	17. Father's Name (First, Middle, Last)	-							
2	d Mer nark	오	Daniel Luther Say		10h Maili	ing Address (S			th Mark	well r, City or Town, State	Zin Code)
Ma	d 2 sl th an 7 is r traur		Amy C. Saylor/Wif							e, Maryla	
e,	1 an Heal em 2		20a. Method of Disposition		20h Place of Disp	osition (Name	of		ate	20c. Location - City	
Baltimore, Maryland 21215-0036	No it it		1 ☐ Buriel 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)		cemetery, cre			Februa 2004 y		110000000000000000000000000000000000000	77.1 1 1
Ħ	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-1 ehow among young to other traumatic event, the Medical Examination at the hullified at Once.		21. Signature of Funeral Service Licens		Metropoli						, Virginia
Ba	Dep Imp		AnneMar	upar,	ker 5	rancis	J. Co	llins	Funeral	Home, In	c. Maryland 2090)
п			23a. Part1. Enter the disease, or comp	lications that caused	d the death. Do not en						Approximate Interval Between
4	Dhysisian		shock, or heart failure. List only o Immediate Cause (Final			1 1					Onset and Death
7	Physician /Medical		disease or condition resulting in death)	· -	rovascular a consequence of):	Accia	ent				Months
5/6	Examiner			Chror	ic Renal F	ailure					Years
	, AS,	Jer	Sequentially list conditions, if any, leading to immediate		a consequence of):						
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
oʻ	e exe ien ar irial-t		resulting in death) Last	Due to (or as	a consequence of):						
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit	dicai	•	d	<u> </u>						
Φ	e as t	Med	IF FEMALE:	20 1/							
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	⊒Ectopic preg				23d. Date of Month	delivery Day Year
0	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death 5 l	Other (spec	:rfy)				
<u>d</u>	that the de ed by the a detached f		Part II. Other significant conditions co	ntributing to death I	out not resulting in the	underlying cau	se given in P	Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ds,	Se Po	d by	•			, •	•		1 □ Ye	es 21≦No 3⊟	Probably 4 Unknown
Ö	w requir been si should	Completed					-		24a. Was a	24h Were	autopsy findings available
3ec	e la has	ш							autops	sy prior	to completion of cause of
of Vital Records		e Co	25. Was case relerred to medical				00.5	Diagonal Country			es 2⊡xNo
₹		00	examiner?	Hospital:	ent 2 ☐ ER/Outpatie	nt 3 🗆 DOA	Other		(Check only on		pecifyHospice
of		n; To	27. Manner of Death	28a. Date of Inju	ury 28b. Time o		: Injury at Work?			ow injury occurred	роспулгозрісе
ion	Attending Phradestrians of the funeral by the funeral	atio.	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	1y Year) Injury	М	1 Yes	2 🗆 No			
Division	Attended octor	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Place of in	jury - At home, farm, si tc. (Specify)	treet, lactory,	office		281. Location (St City or Town		Rural Route Number,
Ö	s afte	Certification;	451101110100	building, or	to. (Spaony)						
	Hospital or Attendi 24 hours after death 5 Funeral Director; 6 stely filled in by the fi	edical			of my knowledge, dea of examination and/or in						
	라는 다 한	Medi	one)	and manner st	tated.		License numl			29d. Date signed (M	
	To To Con	=	29b. Signature and title offcertifier				5635				
	1601		1 - 1 - 1		44-0		2033			February	23, 2004
	1		30. Name and address of person who c				. L.o.	0 = =1 +1	1	1. 1. 00	0.5.5
	Sta	ite	Jospeh Kaplan, M. 31. Date liled (Month, Day, Year)	32. Regist	rar's Signature	1		COCKV11	ie, Mar	yrand 20	δ25
Ī	Regist		FEB 26 20	04 A 2m	were /3	Apa	chal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004, 0784, 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** FEB. 10:35 A^M **FORREST** M. 17. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 ☐ F Director 50 26, 1953 579-72-3321 S. CAROLINA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow n. 11 11011 24 18 marked other than "natural", or Itama 23a or 28a-f aho) Mor other traumatic evant, ina Medical Examinar must be notified at 1 X Yes 2 □ No D.C. NONE WASHINGTON Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1618 T. ST. N.W. 20019 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 MAINTENANCE ENGINEER NATIONAL AIRPORT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If Item 27 is marked o FORREST M. SCOTT SR. DOROTHY MAE BUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OLD CRAIN HWY., UPPER MARLBORO, MD. 20772 BARBARA A. SCOTT/WIFE 5436 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If ite any injuryor oth 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WASHINGTON, D.C. MT. OLIVET CEMETERY 2-24-2004 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE, RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or sa consequence of) Pnysician /Medical resulting in death) Examiner Ineumon, Sequentially list conditions, Examiner dany leading to immedicause. Enter Underlying Cause (Disease or injury ency Virus Inmunodeti that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred examiner? o medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ¥Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; After 1 Anatural 5 Pendina investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) within 24 hours a Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

lchechi 31. Date filed (Month, Day, Year) FEB 23 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. 084196094, m.D

29b. Signature and title of certifier

32. Registrar's Signature

Oxen Hill Rd # 701, 0xon Hill, mp 20745

29c. License number

29d. Date signed (Month, Day, Year)

filed within 72 hours atter

Maryland 21215-0036

of Vital Records,

or Attending Physician:

To the Hospital

11,

6188

State of Maryland / Department of Health and Mental Hygiene 2001; For State Registra Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician FEBRUARY 17, 2004 10:50 PM SHAPTRO /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **BETHESDA** MONTGOMERY SUBURBAN HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1(XM 2□ F 94 456-44-4872 1909 **Director** MAY 12, NEW JERSEY Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene. ant: if Item 27 is marked other than "natural", or Iteme 23e or 28a-f show ary or other traumatic avent, the Macalcal Extendied must be notified at 1 X Yes 2 ☐ No Director **BETHESDA** MARYLAND MONTGOMERY 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? UNITED STATES OF AMERICA 20817 5 DARBY COURT Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 DYes 2 No If Yes, Give Year or Dates: 1943-45 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LAW ATTORNEY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 10 SARAH LUBEL LOUIS SHAPTRO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 DARBY COURT, BETHESDA, MARYLAND 20817 ADELINE SHAPIRO - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: # Ite
any injury or of
once. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GARDEN 02/19/04 5 Other (Specify) OLNEY, MARYLAND uneral Service Licen 21. Signature of DANZANSKY-GÖLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METHICILLIN RESISTANT STAPH AUREUS SEPSIS 3 WEEKS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physicien and for use as the burial-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of). P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown signed by detact Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown abeles mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1 ☐ Yes 2 XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death After Certification: 5 Pending investigation 1 ANatural after death.
Director: All 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie प्र D0060325 FEBRUARY 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REBECCA GROSS, M.D., 10400 CONNECTICUT AVENUE, #606 KENSINGTON, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2004 Registra

DHMH 17 Rev 1/2001

	R	1 - State Registra MEND #23-perMD 1. Decedent's Name (First, Middle, Last		Depa Cer	tificate of	Dealli	ental Hygien Reg. N 2. Date of Death	e 200L	3. Time of Death
	sician edical	James G. Shirlen	, Sr.				Month D FEBRUARY	18 2004	3:15PM
	miner	4a. Facility Name (If not institution, give Doctors Community			4b. City, Town, o Lanhai	r Location of Death M		c. County of Deet rince Ge	
Funer Direct		5//-24-1402		birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Oct. 31, 19	r) 9. Bird Co Nor	hplace (State or Foreign buntry) th Carolina
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	eorge's 10c. City, To		e Park	- -			10d. Inside City Limits 14 Yes 2 ☐ No
th with the 23s or 28s	ai Director	10e. Street and Number 4718 Nantucket Roa	ad		10f. Zip Code 2074	0		itizen of What Co United S	
ING 21215-UU30 be filed within 72 hours after death with the Maryland stal Hygiene. all thygiene. outher than "natural", or Items 23a or 28a-f show event, the Mcdical Examine Trullite an utilitied at	by Funeral	11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1945–1946 	13. V	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 X No	ispanic Origin? (Spean, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-UU30 d 2 should be filed within 72 hours aft th and Mental Hygiene. ?? Is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's Edu (Specify only highest grad	e completed) College (1-4or 5+)	(Give I	O NOT use retired	during most of working	g	Kind of Business	Industry overnment
illa Z	To Be Co	17. Father's Name (First, Middle, Last) Tohn Marytin Shir	rlen			18. Mother's Name Orlie M	(First, Middle, Maide	in Sumame)	VCITALCITC
Mary and 2 shou alth and M 27 is mar r traumat		19a. Informant's Name/Relationship (T) James G. Shirlen,				and Number or Rural rive Silve			
Baitimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Importants if item 27 is marked any inlury or other traumatic as	Ċ.	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State Fort	terv. crem	sition (Name of latory or other place oln Ceme	tery 2/23/		Location - City or entwood,	
permit. Departr Imports	ouce.	21. Signature of Funeral Service Licens Donald U.B.	rgevart	44	00 Powde	ss of Facility Borgwardt r Mill Rd.	Beltsvil	ome, P.A le, Mary	land 20705
Physicia /Medic Examin	al	23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	indificult the death. Die cause on each line. a. Due to (or as a consequence)	- 1	er the mode of dyin	g, such as cardiac or Cell Ca	respiratory arrest,		Approximate Interval Between Onset and Death
b8 / bU, ficate be executed physician and st the burial-transit	al Examiner	Sequentially list conditions, if any leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence)						
HECOTOS, P.O. BOX 08/ The law requires that the death certificate ten has been signed by the attending phys hage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of deli Month	ivery Day Year
rds, r. quires that t n signed by uld be detad	ed by Ph	Part II. Other significant conditions co	ntributing to death but not resulting	g in the un	derlying cause giv	en in Part I.	23e. Did tobacco		the cause of death?
	. ∣ <u>o</u> .						24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
I VICAL MO ysician: The is certificate hi director, page	Be	25. Was case referred to medical	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Sutnations	oth Oth	26. Place of Death		C = 0.15 - 1 (C	
VISION OF VICA Attanding Physician: r death. actor: After this certifics by the funeral director;	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Time of Injury	28c. Injun Wor		e 5 Residence 8d. Describe how in		(Ary)
DIVISION OF To the Hospital or Attanding Ph within 24 hours atter death. To the Funaral Diractor: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office	2	8f. Location (Street a City or Town, Sta		ral Route Number,
To the Hospital within 24 hours a To the Funaral to completely filled	edical	29a. Certifier Certifying Phy (Check only one)	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	lge, death and/or inv	occurred at the tin estigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause(d at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
1	Me	29b. Signature and title of certified			29c. Licens	e number	29d. D	ate signed (Month	n, Day, Year)
ω		30. Name and address of person who co	ompleted cause of death (Item 23a	a) (Type, f	Print)	2000/		11-1/0	7
7	State	MCHATL BOKA 31. Date filed (Month, Day, Year)	ompleted cause of death (Item 23a) 23. Registrar's Signature	BAL	Sparke	9UE. 50170	= 107, Con	LEGE RAN	K, 20740
Reg	jistrar	FEB 2 4 20	U4 Papara	D	spark				

DHMH 17 Rev 1/2001

Registrar

*	Physicia /Modic	ın	Decedent's Name (First, Middle, Las ESTHER	(Esther R. Silve	rman					2. Date of De Month FEBRUA	Day	Year 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of	of Death	-	4c.	County of Dea	th
	LAGIIIII	•	SUBURBAN HOSP	TAL.		BE	THES	DA			MO	ONTGOME	RY
	Funeral		5. Social Security Number 6. So	7. Age (In yrs. last b		If Under Months	1 Year Days	If Under	Min.	8. Date of Bis (Month, Da	iy. Year)	Co	thplace (State or Foreign puntry)
	Director		138-074968	90	Yrs.				F	EB. 15	,1914	NEW	JERSEY
and	3	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Loc	ation							10d. Inside City Limits
Mary	f sho	ō	MARYLAND MONTGO	MERY RO	OCKV1	LLE							Y∏Yes 2 No
with the	a or 28e-	Direc	10e. Street and Number 1801 EAST JEFFE	RSON ST. #224		10f. Zip	Code 208	352		Ų		en of What Co	ountry? S OF AMERICA
bours after death with the Maryland	ral', or items 23a or 28e-f show Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No tt Yes, Give Year or Dates:				ispanic Ori n, Mexican Specify:	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.)		4. Race - Ame Black, Whit	
		Completed	15. Decedent's Ed (Specify only highest gra		(Give k	ent's Usua and of wor ONOT us	k done d	turina mos	t of workii	ng	16b. Kir	nd of Business	/Industry
within 72	than	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		DMEMA		7			O	N HOME	
	other		17. Father's Name (First, Middle, Last)		Щ), III.II	KLIK	18. Mothe	er's Name	(First, Middle	-		
9 9	0 0 m	To Be	MICHAEL FER	DINAND					PAUI	INE RA	PPAP	ORT	
Mai yiaiid	umat		19a. Informant's Name/Relationship (** * *							-	Town, State,	
	alth a		MARLENE SILVERMAN	- DAUGHTER	3701	CONN	ECTI	CUT	AVE.	NW, WA	SHIN	GTON, D	C 20008
בי ה ה	# # # P		20a. Method of Disposition 1 XBurial 2 Cremation 3 C		tery, crem	atory or or	ther plac			ate		cation - City or	
2008	ment ent: h ury o		`4 Donation 5 Other (Specific	BARON	HIRS	SH. CE	METE	ERY	FEB 2	23, 200	4 ST	ATEN IS	T.AND, NY
Daltimore,	Department of Health and Men Importent: If Item 27 Is marks any injury or other traumatic once.		21. Signature of Funeral Service Licer	isee	D/ 1	Name an NZAN 170 R	d Addres SKY OCKV	GOLDI TILLE	BERG PIKE	MEMORI E, ROCK	AL CI	HAPEL, E, MD 2	INC. 0852
	Medical xamine purish transit	Icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ASPIRATION P Due to (or as a consequence b. CONGESTIVE C Due to (or as a consequence c. Due to (or as a consequence d.	e of): ARDI('ATHY	7					Onset and Death
Goath Certifical	e attending phid for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pr Other (sp					2	3d. Date of de Month	livery Day Year
, s	igned by	y Ph	Part II. Other significant conditions of	ontributing to death but not resulting	j in the un	derlying c	ause give	en in Part I		23e. Did	tobacco u	se contribute t	o the cause of death?
2	been sig should b									1 🗆	Yes 2	No 3□P	robably 4 □Unknown
The law requires that the	nis certificate has been I director, page 2 should	Completed				· · ·					s an psy ormed? 2 X io	prior to death?	utopsy findings available completion of cause of
Vitai	ertific ictor,	Be (25. Was case referred to medical examiner?						e of Death	(Check only	one)		
OI VILLE	his ca	은	1 ☐ Yes 2X No		Outpatient		- 1	4 1140	-			Other (Spe	ecify)
	After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	o. Time of Injury	M 1	8c. Injun Worl	yat k? Yes 2□		28d. Describe	how injur	occurred .	
	s after deat if Director: id in by the	Sertific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		farm, stre	et, factory	, office				(Street and wn, State		ural Route Number,
ביים ביים	within 24 hours after death	edical (nysician: To the best of my knowled niner: On the basis of examination and manner stated.									
	within 2 To the complet	Me	29b. Signature and title of certifier			290	. Licens	e number		}	29d. Dat	e signed (Mon	th, Day, Year)
	2		> Alpany	omen M.) .	I	276	60			FEBR	UARY 21	, 2004
		111	1 //.	completed cause of death (Item 23:	a) /Tuna I	Drint							

DHMH 17 Rev 1/2001

Silverman, Esther

			1 - For State Registrar	State of Maryland	/ Depa	artment of tificate of	Health and Death	Mental Hyg	jiene 20	04	07854
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) SAMUEL 4a. Facility Name (If not institution, give s 24229 NEWBURY R	L. treet and number)	SMIT	4b. City, Town,	or Location of Dea	2. Date of Dea Month FEBRUAR	Y 19 2 4c. County	OO4 of Death	3. Time of Death 5:23 P M
	Funeral Director		5. Social Security Number 6. Sex		birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs		Year)	9. Birthpla	ce (State or Foreign y) NSas
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If team 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Meuthal Expringer must be notified at anone.	Funeral Director		Was Decedent Ever in U.S. Armed Forces?	<u>aithe</u>	ers burg 10f. Zip Code 2	0882 Hispanic Origin? (5 ban, Mexican, Puer		14. Raci		ates 1 Indian,
Maryland 21215-0036	ad within 72 hours aft glene. er than "natural", or i t. the Mudfaal Expres.	Completed by F	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	1 ZYes, Give WWII ation completed) College (1-4or 5+)	6a. Deced (Give i			rking	Specify 16b. Kind of Bu	Wh i	ite stry rch Lab.
Maryland	nd 2 should be filed Ith and Mental Hygis 27 is markad other rtr∎umatic event, II	To Be (17. Father's Name (First, Middle, Last) Oliver Smith 19a. Informant's Name/Relationship (Type Violet C. Smith /				18. Mother's Na. Jessi st and Number or Re	ural Route Number	On City or Town,	State, Zip Co	ode) 0882
o,	rmit. Pages 1 an partment of Heal portant: If Itam 2 y injury or other ce.		20a. Method of Disposition 1 Burial 2 Cremation 3 Recify) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	omoval from State 20b. Place came Metro	of Dispos etery, crem OPOli	ition (Name of atory or other pla tan Crei	ace)	1/04	Alexan	City or Towr	n, State
	nysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	M - 0047C ations that caused the death. De cause on each line. Myelofil Due to (or as a consequence	Oo not ente	P. 0. In the mode of dy	Box 5038,	Laytons	/ille, I	A In O	20882 Opproximate Interval Between Onset and Death
,160,	ate be executed which is a property of the purial-transit of the purial-transit of the purial-tra	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liseas or injury that initiated events resulting in death) Last d.	Due to (or as a consequence							
O. Box 68	death certific e attending pl id for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death		Ectopic pregnand Other (specify) _	ey Ey		23d. Date Mon	of delivery th Da	ay Year
Hecords, P	The law requires that the table has been signed by thoage 2 should be detached.	ted by PI	Part II. Other significant conditions cont	ributing to death but not resulting	g in the un	derlying cause gr	ven in Part I.	23e. Did tob			cause of death?
		e Completed	hypercoagnable ?	itate				24a. Was ar autopsy perform 1 Yes 2	ned? de	/ere autopsy rior to compl eath? Yes 2[y findings available letion of cause of
ם כו	ng Phy fter this meral d	ertification; To B	examiner?		Outpatient Time of Injury	28c. Inju	her: 4 🗆 Nursing H	ome 5 Resider 28d. Describe hor	nce 6 Othe		
DIVISION	pital or ours afte arat Dir filled in	O	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)			ime data and place	28f. Location (Str. City or Town,	, State)		·
:	vithin 24 hc To the Fun completely	Medical	(Check only 2 ☐ Medicat Examine one) 29b. Signature and title of certifier	er: On the basis of examination and manner stated.	and/or inve	29c. Licen	opinion, death occu	rred at the time, da	te and place, and place, and place, and place signed	(Month, Day	e cause(s) y, Year)
ľ	2+1		30. Name and address of person who com	appleted cause of death (Item 23a 9707 Medical (e					o 2085	V	
A	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 3 200	32. Registrar's Signature	5	Locar	61			•	

			For	Plea			nt in Blac laryland /	Depa	artmen	t of H	lealth	and M					07	855
			Registrer AV		TH2/25/0	4,BMW,N	1 bCo	Cei	tificat	e of I	Death		2. Date of	Reg. N	lo.			
	Physici	ian	1. Decedent's Nam	ylin	Thoma	c Sn	owden						Month Febru	D	ay 21	Year 2004		30 AM
	/Medio Examir		4a. Facility Name (4b. City,	Town, or	Location	of Death	COTO		lc. County	-	0- 1	JU 15
1_		ici	Shady 5. Social Security		Adven		Hospi		If Under		CKVi		8. Date of I	Birth 1.8	MON			ate or Foreign
н	Funeral Director		None	1050.	1 ₫¾M 2[go ()	Yrs.	Months	Days 3	Hours	Min.	Feb.	Dav. Yea	r)	Cour	ryl	
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	arylar show	2	10a. State MD	10b. County	ntgome	rv	10c. City, Tov		cation GOME	rv '	77i11	ane				'		le City Limits Yes 2 ☐ No
	the M	ectc	10e, Street and Nu						10f. Zip		·	<u> </u>		100.0	Citizen of V	hat Cour		
	with with	Ö	No. of the Contract of the Con		on Run	Roa	d		101. 2.10		886			109.0		5 . A .	yı	
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show amportant: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at an ance.	Funeral Director	11. Marital Status 1 ☑ Never Man		12. Wa Am		Ever in U.S.		Vas Deced f Yes, spec	dent of H cify Cuba			ecify Yes or Rican, etc.)	No-		- Americk, White,		n,
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	e filed al Hygi I other vent, I	Be C	17. Father's Name		Last)		· .						(First, Midd			θ)		
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Maryland	2 short and rism		19a. Informant's N															20886 e, MD
_	1 and Health em 27 ther t		Sheila 20a. Method of Dis		son (Moth	er 20b. Place o				2011		ate	-	Location -			
Baltimore,	ages int of I		1 🗆 Burial 2	☑ Cremation	3 □Removal	I from State	camata	ary, cren	natory or o	ther plac					Lexar	•		
Ħ	permit. Page Department Importent: If any injury or		* 4 □ Donation 21. Signature 1 Fe			P							WDEN					
Ba	Depariment Department Important in any ire		Le	rege	XX	war	ch-1		246	N. 1	Wash	. St	., R	ockv	7ill∈	e, M	D 2	0850
	Pnysician		23a. Part1. Enter shock, or hee Immediate Cause disease or condition	(Final	- Parker		d the death. go ine. VENTR							THE RESERVE OF THE PERSON NAMED IN			Onset a	mate Between and Death
1	/Medical Examiner		resulting in death)		_ a		a consequence	of):						- Andrews			91	1 1
		iner	S-quentially list co if any, leading to in cause. Enter Unde Cause (Disease or	onditions. nmediate arlying	b. —		MONGVE a consequence	of):	lyper	tens	îon						Ò.	12 days
60,	be executed ician and burial-transit	al Examin	that initiated event resulting in death)	S	c. D	ue to (or as	a consequence	of):										
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P.O. Box (The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur	by Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	nonths? ☐ No	1 4	Live birth	of pregnancy 2 Fetal death t time of death		Ectopic pro						23d. Date Mon		ny Day	Year
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ō	s bee	olete		Hypo	tensic	N							24a. Wt		24b. W	ere auto	sy findir	ngs available
Re	The la	Completed											aut per 1 ☐ Yes	opsy formed? 2 N	d	rior to cor eath? Yes		of cause of
ita	slan: artifica ctor, I	Bec	25. Was case reference examiner?	rred to medica	ı		"					of Death	(Check only					
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Ĕ	ling P	in oi	27. Manner of Deat 1 ⊠Natural	5 Pendir	ng	Date of Inju (Month, Da	ly Yeer) 28b.	Time of Injury	M 2	8c. Injury Work	rat ⊲? Yes 2.∐		28d. Describ	e how inju	ury occurre	bd		
isi	Attend death ctor: y the	Certification;	2 Accident 3 Suicide	investi 6 ☐ Could	not be	Place of In	jury - At home, fa	arm, stre			163 2	-	28f. Location	(Street a	and Numbe	r or Rura	Route N	lumber.
ē	after after Dire	erti	4 Homicide	determ	lined	building, e	c. (Specify)		,	,				own, Sta				
	To the Hospitel or Attending Physiclen: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ledicai C	29a. Certifier (Check only one)	1 Certifyin 2 Medicel	Examiner: On	To the best the basis of manner st	of my knowledg of examination ar ated.	e, death	occurred a estigation,	at the tim in my op	e, date an pinion, dea	id place, a	and due to the	e cause(s e, date ar	s) and mar nd place, a	ner as st nd due to	ated. the caus	se(s)
	To the within Fo the somple	₩ W	29b. Signature and	title of certifie	1 0				29c	License	number			29d. D	ate signed	(Month, I	De <i>y</i> , Yea	r)
	1			1/10	unthe	M.	1)		1	0 (051	310)	FE	BRUI	ary:	212	.004.
	,		30. Name and add		who completed		death (Item 23a)			1 _M	edic	al (Cente					
	Sta Registr		31. Date filed (Mor	EB 25	2004	32. Registr	rar's Signature	4	Spa									
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 1:53 P 24, FEB. 2004 KELLI J. STANDEN /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner LOTHIAN ANNE ARUNDEL D ST. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | FEB. 12,1966 Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 ☐ M 2 X F Yrs. MARYLAND 38 Director 219-98-8415 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylani Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examinar must be notified as once. 10a, State 10b. County 10c. City. Town or Location Y☐Yes 2☐No Director ANNE ARUNDEL LOTHIAN MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 55 D ST. 20711 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify. þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BARE MARY JANE DICKERSON ٥ DALLAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) D ST., LOTHIAN, MD. 20711 Τ. STANDEN/HUSBAND 55 JAY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ Removat from State CHAMBERS CREMATORY 2-26-2004 RIVERDALE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FUNERAL HOME & CREMATORIUM, P.A. Chamberes M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final USTO. **Physician** hel disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 □ No 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 Inpatient Other: 4 Nursing Home within 24 hours after deam.
To the Funerel Director: After this c 1 Yes 2 NO Certification; To 2 ER/Outpatient 3 DOA 5⊟Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Matural Injury 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the cause (s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and/tiple of certifier License numbe 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person, MD BYS 6 R 32. Registrar's Signature 31. Date tiled (Month, Day, Year) State FEB 26 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene. 004 Certificate of Death AMFND#260erMD2/27/04.BMW.McCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month LYUDMILA STEPANOVA nmn 02 23/ /Medical 2004 11:00AM 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Locetion of Death Examiner 4c. County of Death 434 Mc Arthur Drive Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdev) 8. Date of Birth (Month, Day, Yeer) 10/17/1950 **Funeral** Birthplace (State or Foreign Country)
____ Months Days 1 M 2 K F Yrs. Director 212-41-1218 53 Ukraine Usual Residence of Decedent permit. Pages 1 end 2 should be illed within 72 hours after death with the Meryland Department of Heatth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic evant, the Medical Examiner must be notified at 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 ☑ No Maryland | Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 434 Mc Arthur Drive 20850 Funerai USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Ę Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hair Stylist Hairdressing 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vladmir Kabanez Vera Kabanez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anatoliy Rondel -husband 434 McArthur Dr. Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10 Norbeck Memorial Park 2/25/04 Olney, Maryland Funeral Service Livensee 22. Name and Address of Facility Advent Funeral Service 7211 Lee Highway Falls Church, Virginia 22046 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Sepsis Examiner 24hrs Due to (or as a consequence of): Examiner Pneumonia or Attanding Physician: The law requires that the death certificate be executed 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Division of Vital Records, P.O. Box 68760, Metastatic cancer of liver & lung Physician/Medical 3 years Due to (or as a consequence of): Colon Cancer signed by the at a be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ page 2 should Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ₺ No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury To the Hospital or Attanding within 24 hours effer death.

To the Funeral Director: Aft completely filled in by the fun 2 Accident 1 Tyes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Rocku, LLE, MD. 20850 SHPAK 140 121 CONGRESSIONAL LANE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 27 2004

			1 - For State Registrar	State of M			rtment of F		and M			2004	07	858
	Physici	an	1. Decedent's Name (First, Middle, Last							2. Date of Dea Month		Year	3. Time of	
,	/Medic	al	Joseph Edward		Sr.		4h Cihi Taua	-1	4 Dooth	Februa:		, 2004	7:50	A M
	Examin	er	Shady Grove A		cent	er	4b. City, Town, o		or Death			ntgomer	v	
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	r 28a	lrec	10e. Street and Number		<u> </u>		10f. Zip Code				10g. Citize	n of What Cour	ntry?	
	th with	Funeral Director	123 Grove Avenue					20	880		Unit	ed Stat	es	
	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Ori an, Mexicar	gin? (Spe	ecify Yes or No- Rican, etc.)	14	. Race - Americ Black, White,		
36	rs afte	by F	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ If Yes, Give Year or Dates:		1	☐Yes 2X No	Specify:			S	pecify:	T T1	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f ehow the Madical Examinar must be notified at	ted	15. Decedent's Edu	ucation		Decede	ent's Usual Occup	ation			16b. Kind	of Business/Inc	White	3
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and	be fill hall Hed out	Be	17. Father's Name (First, Middle, Last) Joseph Stolz							(First, Middle,		/		
Maryland	should nd Me mark matic	2	19a. Informant's Name/Relationship (T)	voe. Print)	19b	. Mailing	Address (Street			atherine			Code)	
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ore,	of Hei		20a. Method of Disposition		20b. Place of	Disnos	ition /Name of			ate	20c. Loca	tion - City or To	wn, State	
Ĕ	Pag ment ant: I		1 ঐBurial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		Gate	or {	tory or other place leaven emetery		20	1ary 23	Silv	er Spri	ng, MD)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 ie marked other then "naturel", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licens	y I e, Ga	eVol Fullithersh	nera ourg,	1 Home, MD 208	10 Ea 77	ıst					
	Physician /Medical Examiner	ılner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or as	a consequence of a consequence of	さい of): かか、本	۵	g, such as	cardiac o	respiratory an	rest.		Approximate Interval Bett Onset and I	ween
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Division		Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury · At home, fai c. (Specify)	rm, stree	et, factory, office		2	28f. Location (Si City or Town	treet and N n, State)	lumber or Rural	Route Numi	ber,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	29a. Certifier (Check only one) 14€ Certifying Phy 2 Medicaf Exami	sician: To the best iner: On the basis of and manner sta	examination and	dor inve	occurred at the timestigation, in my op	ne, date and pinion, deat	d place, a	and due to the coed at the time, d	ause(s) an ate and pla	d manner as sta ace, and due to	ated. the cause(s))
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	Registr		FEB 23 200	14 Sens	now for	9	Sporks							

DHMH 17 Bev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ROBERT T. SMALLWOOD State of Maryland / Department of Health and Mental Hygiene 1 - For State Unpend Item#23a,27,Per ME,C829,3/16/6/4##8cate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 16, 2004 1035 A M FEB. Robert т. Smallwood /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5819 MLK HIGHWAY SEAT PLEASANT PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 🔯 M 2 🗆 F 55 578-68-7985 Feb.28, 1948 Director N.C Usual Residence of Decedent Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show Examiner must be notified at 1X Yes 2 No Director DC Washington 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 1301 Saratoga Ave., N.E. 20018 Itama 23a United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Bleck, White, etc. on of Health and Mental Hygiene.

It if Itam 27 is marked other than "natural" ---or other traumatic event ☐Yes 21 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates: **Black** 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Private Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William T. Smallwood Dorothy Roscoe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1080 Mt. 011 vet. Rd M F 19a. Informant's Name/Relationship (Type, Print) 1080 Mt. Olivet Rd. N.E. Washington, DC 20002 N.E. Roma Smallwood/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State rtment of Department of Important: If It eny injury or o 1 Burial 2 Cremation 3 Removal from State Resurrection Cem. 2/21/04 * 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Md. 22. Name and Address of Facility Hodges & Edwards F.H. permit. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Atherosclerotic Cardiovascular Disease **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director; Atter this certificate has been signed by the attending physician and Due to (or as a consequence of) anding physician a use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death P.O. P 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 1 Yes 2 No 3 Probably 4 No Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Pos 2 No 24a. Was an autopsy performed? 1 Yes 2 🗆 No Be (26. Place of Death (Check only one) 25. Was case referred to medical examiner? 1. Yes 2 No AT SCENE Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) ဥ 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier FEB. 17, 2004 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 THEDOORE MIKE 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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Š	d 2 br		Geraldine Spriggs	s/Wife		6106	P1um	Wav		C	linton.	Ma	aryland	20735	
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Вох	leath certific attending p I for use as t	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregna		Ectopic pre	egnancy				1	23d. Date of de Month		ear
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	d 2 should th and Men 7 is marke traumatic	ToB	Clifford W. S 19a. Informant's Name/Relationship Michael W. Schaf			-		nd Numbe	ror Aural	Dursti Route Number Glenw	er, City o		tate, Zip	
Baltimore,	permit. Peges 1 and Department of Heali Important: If Item 2 any njury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State Ced	Place of Disponentery, createry, cre	matory or or .1 Cem	ther place leter	y 0	2/17	/2004 sch's F	Sui	tland	l, Ma	ryland
فا	Physician /Medical Examiner poural-transit	cal Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediete Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last	mplications that caused the deat by one cause on each line. a. Carcinoma Due to (or as a consequence of the	h. Do not ent - Meta uence of): nentia uence of): al Eder	ter the mode	e of dying			Hyatt		.le,	5	Approximate Interval Between Onset and Death Months Years Years
O. Box 68	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregns 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3	□Ectopic pro □ Other (sp						23d. Date Mont		ry Day Year
cords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	inderlying ca	ause give	en in Part I.			Yes 2	□ No 3	Proba	e cause of death? ably 4 Unknown by findings available
f Vital Records,		To Be Completed	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DO	Othe	AC.		autor perfo 1 ☐ Yes (Check only one 5 ☐ Resident	rmed? 211 No one)	de 1 (ath?] Yes	
Division of	ding I	Certification:	27. Manner of Death 1 Anatural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide	be 380 Place of Injuny - At h		м		at ?? ∕es 2 □ l	No	8d. Describe I 8f. Location (: City or Tox	Street an	d Number		l Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical Ce		Physicien: To the best of my kno aminer: On the basis of examina and manner stated.							date and	i place, an	nd due to	the cause(s)
0	To the complet	M	29b. Signature and till contiller 30. Name and address of person wh	to comileted cause of death (Itar	n 23a) (Tvne	.0	License	number				te signed i		Day, Year) , 2004
	Sta Regist	ate	B.G. Manejwala, 31. Date filed (Month, Day, Year) FFR 18 20	M.D., 14201 Lau Registrar's Signa	rel Pa	rk Dr	ive,	Laur	el,_	MD 20	707			

			1 - For State Registrar	State of Maryla		rtment of He			iene •g. No 200	4 07863
	Physici	an	1. Decedent's Name (First, Middle, Las	RANKLIN	SHAW			2. Date of Dear Month	th	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give Millennium Health	street and number)		4b. City, Town, or Fort	Location of Death Washingt		4c. County of I	Death George's
	Funeral Director		5. Social Security Number 6. Sec. 239–40–5969		s. last birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 5 29	Year)	Birthplace (State or Foreign Country) orth Carolina
	r the Maryland	Director	Usual Residence of Decedent		Fort W	ation Jashington 10f. Zip Code	n	1	0g. Citizen of Wha	10d. Inside City Limits 1 ☑ Yes 2 ☐ No at Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Exactling translibe trailing at 2006.	by Funeral D	9600 Pamelia F 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Novorced	1ace 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No HYes, Give Year or Dates:	If	20744 /as Decedent of His Yes, specify Cubar	spanic Origin? (Spanic Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, \	A . American Indian, White, etc. Black
Maryland 21215-0036	d within 72 hou giene. ar than "natura r the Medical E.	Be Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th		(Give I life. D	ent's Usual Occupa ind of work done di O NOT use retired)	uring most of work	ing	16b. Kind of Busin	ess/Industry
ryland	should be filed ind Mental Hygis s marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) John M. Shaw 19a. Informant's Name/Relationship (7)	una Print)	19h Mailin	g Address (Street a	18. Mother's Name Janie ad Number of Rus	Ste	phens	ta Zin Codal
altimore, Ma	Pages 1 and 2 s nent of Health an int: If item 27 is ury or other trau		Edward Stephens/ 20a. Method of Disposition 12 Burial 2 Cremation 3 C	Cousin 20b.	9600 :	Pamelia P lition (Name of atory or other place	1. Fort	Washin t		land 20744
Baltim	permit. Pa Departmen Importent: any injury once.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			Name and Address	s of Facility J.	B. Jenk		arolina ral nome and 20785
10000000000000000000000000000000000000	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the dearne cause on each line. Pancreation Due to (or as a conse	ath. Do not ente	r the mode of dying	, such as cardiac o	or respiratory arre	əst,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.						
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)	- C - Ta-		23d. Date of Month	l delivery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions of	ntributing to death but not re	sulting in the un	derlying cause give	n in Part I.	23e. Did tob		te to the cause of death? Probably 4 XUnknown
al Records,		Completed						24a. Was a autops perform 1 - Yes 2	y prior ned? deat	e autopsy findings available to completion of cause of th? Yes XXNo
of Vita	Attending Physician: Thir death. ector: Atter this certificate by the funeral director, pag	To Be	27. Manner of Death	28a. Date of Injury	ER/Outpatient	Other	4 > Nursing Ho	me 5 Reside	ence 6 Other (Sow injury occurred	Specify)
Division of Vital	I or Attending I after death. Director; After I in by the funer	Certification;	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) 28e. Place of Injury - At building, etc. (Spec		M 1□Y	es 2□No	28f. Location (St. City or Town	reet and Number o	or Rural Route Number,
	Hospital 4 hours Funeral ely filled	edical Cer	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my opi	e, date and place, inion, death occurr	and due to the ca ed at the time, da	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1		29c. License			9d. Date signed (M	
	6		30. Name and ddress of person who of						February	
Ė	Sta Regist		H. Herbert Was 31. Date filed (Month, Day, Year) FEB 1 8 2004	Registrar's Sign			Т рвол по	ort wash	ington,	Maryland 2074

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev Vear **Physician** FEBRUARY NATHANIEL THOMAS SLAYTON 17, 2004 5:27AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner FORT WASHINGTON HOSPITAL CENTER FORT WASHINGTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys XIX M 2□ F Yrs Director 20, 38 0105 VIRGINIA Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Menyland Depertment of Health and Mental Hygiene. Important: If New 27 is marked other than "natural" ---- any injury or other traumatic accounts. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2 No Director MARYLAND PRINCE GEORGES FORT WASHINGTON 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2908 GOSPORT COURT 20744 Funeral USA 11. Maritel Status 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th Wonder Bread Laborer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Mae Slayton 2 Elijah Slayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Gladys Slayton/wife 2908 Gosport Ct. Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, Slate 1 XBurial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Spotswood Holiness Cemetery 2-20 Campbell County, VA 22. Name and Address of Fecility
Marshall's Funeral Home of MD 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20744 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner 0 physicien end s the bunel-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last ue to (or es e consequence of) Division of Vital Records, P.O. Box 68760. A Due to (ox as a consequence of): USB BS Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 should 24a. Was an autopsy performed? hes this certificate T□ Yes 2\ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lippatient Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigetion Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours e Hospital T Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signature and title of certified 29d. Date signed (Month, Dey, Yeer) 29c. License numbe M 0046046 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Mirza Alikhani Rcl. 1-ort Washington Md. 20144 IVINASTON 31. Date filed (Month, Day, Year) Registrer's Signeture State FEB 1 8 2004 Registrar

DHMH 16 Rev 6/95

Type of Time in Black	illuonaio illia		p	200
State of Maryland / D	epartment of He	ealth and Menta	al Hygiene	7111

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 31, Physician 8:30 Shapinsky Ам Harold 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Collingswood Nursing & Rehabilitation Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign Country) New York 6. Sex **Funeral** Days Hours 1⊠M 2□F 78 Yrs. May 21, 123-04-0316 1925 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 27 is marked other then "natural", or Items 23e or 28e-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Montgomery Rockville Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 299 Hurley United States Avenue Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Korean Year or Dates: War Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Artist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be n and Mental ! Alice David Shapinsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4201 Butterworth Pl., N.W. Washington, D.C. 20016 Kate Shapinsky (Wife) nt of Health other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 6 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance Feb. 2, 2004 permit. Page Department of important: If any injury or Clarksburg, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral And Cremations Services Muceus 933 Gist Avenue Silver Spring, MD 23a. Part1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one parties of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Dementia /Medical Due to (or as a consequence of): Examiner Seizure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physician and use as the burial-transit the Hospitel or Attending Physician: The law requires that the death certificate be executed Hypertension Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Tes 2₺ No 3 Probably 4 Unknown been sig Hypothyroid Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Constipation has e 2 autopsy performed? page 1 Yes 2X No certificate 2 🖾 No Be 25. Was case referred to medical 26. Place of Death (Check only one) director examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 X Naturat 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 9 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number S-SHAMIM D59284 Feb. 16, 2004 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shamim, M.D.; 1299 Lamberton Dr., Silver Spring, Md. 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2004 Skinner Feb. 8 9:25A J. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Montgomery General Hospital Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 25 F Director 578-30-861<u>3</u> April Pril 22. 1924 Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State if them 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at 1√ Yes 2 No Director Md. Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1263 Viers Mill Road #309 20853 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private LPN Unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Skinner Fannie Eaton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1144 1st St., N.W. 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 st Department of Health and Importent: If Item 27 le m eny injury or other traum once. 1144 1st St. Washington, N.W. 20001 George Brown/son 20c. Location - City or Town, Stete 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/14/04 Creek Cem. Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Rock 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signatule of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, Md.20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Renal Failure days /Medical Due to (or as a consequence of) Examiner Hypertension 4 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Live birth 2 Fetal death Year Month Day ò in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo detached 9□ Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Atrial Fibullation 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2X No 1 Yes Attending Physician: 25. Was case referred to medical axaminer? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပို 1 Yes 2 No 28b. Time of 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely the state of 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 2 D26540 February 8, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schoenberge, M.D., 16220 Frederick Rd., Gaithersburg, Md. Carl \mathbf{T} . P. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 7 2004 Registrar

DHMH 17 Rev 1/2001

State

Registrar

FEB 1 7 2004

ORIGINAL

			For State of Mary		rtment of He tificate of D			iene •g. No. 20	104	07868
	Physici	an	1. Decedent's Name (First, Middle, Last) RAYMOND SCOT	T SR.			2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Lo		1-EBRUAN	4c. County PRINC		
	Funeral			n yrs. last birthday)	If Under 1 Year	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)			lace (State or Foreign
t.	Director		212-14-5616	Yrs.	Month's Days	110013	Jan.	4 1914	VIRG	ÍNIA
	anyland show	٦.	,	Oc. City, Town or Loc					1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28a-f	Funeral Director	MD PRINCE GEORGE S 10e. Street and Number	MIICH	ELLVILLE 10f. Zip Code		1	0g. Citizen of V	Vhat Coun	
	ath with	ralD	11807 SHADY STONE TERRACE		20721			U.S.	A. e - Americ	
036	urs after de al', or Itams Examiner r	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If	Vas Decedent of Hisp Yes, specify Cuban, ☐ Yes 🌠 No	Mexican, Puerto l Specify:	city Yes or No- Rican, etc.)		k, White,	
Rymon D. Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene. Department of Heath and Mental Hygiene and many injury or other traumatic event, the Medical Examinal mission of the filed at any injury or other traumatic event, the Medical Examinal mission of the filed at any injury or other traumatic event, the Medical Examinal mission of the filed at any injury or other traumatic event, the Medical Examinal mission of the filed at any injury or other traumatic event, the Medical Examinal mission of the filed at a	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I	ent's Usual Occupation of work done during NOT use retired)	ring most of workii	ng	16b. Kind of Bu		dustry NMENT
94mod 2	be filed valued by the filed value of the filed val	Be	4TH 17. Father's Name (First, Middle, Last) PETER SCOTT	1	COLLECTIO	8. Mother's Name VIRGINIA				NHENI
S S	should and Men s marka numatic	₽	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and	d Number or Rura	l Route Number	; City or Town,		
	1 and 2 Health a lem 27 is		WILLIAM SCOTT/Son 20a. Method of Disposition	20b. Place of Dispos	BRIGHTSEA			ENARDEN 20c. Location -		
Saltimore.	Pages ment of ent: If it ury or o		1 ⊠Buriai 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	HARMONY		2-25		LANDOVE		
Batt	permit. Departr Importe any inji		21. Signature of Funeral Service Licensee		Name and Address 74 LANDOV					
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	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a condition or a condition or a	over when consequence of):	/ ://. L'= =					
	pe is	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	onsequence of):	milano					
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ivisio	or Attending ifter death. Director: After in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could to the determined 28e. Place of Injury building, etc. (c	- At home, farm, stre Specify)		s 2 🗆 No	28f. Location (SI City or Town		er or Rura	l Route Number,
٥	Hospite 4 hours Funeral	Medical Ce	29a. Certifier (Check only one) 29a Certifying Physician: To the best of m	camination and/or inv	occurred at the time, estigation, in my opin	date and place, a	and due to the card at the time, d	ause(s) and ma ate and place, a	nner as st	ated. the cause(s)
	To the To the complet	Mec	29b. Signature and title of certifier		29c. License r	,	2	9d. Date signed	(Month, I	Day, Year)
	NE	1	30. Nam and address of person who complet ause of deat	th (Item 23a) (Type I		,201	1	Money	20,	rocy
CI	2 (3)		MICHAEL WALGER SO.	575 MAIN	5TREET	SUITE	351 LA	UKEL, 1	403	20706
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 4 2004	Signature	W .					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Ray Allen Stine February 6:05P 14, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherry Lane Nursing Center Laure1 Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 216-16-0277 80 Director Nov 12, 1923 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Modical Executarization notified at 1X Yes 2 No Funeral Director Prince George MD Mount Rainer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4105 32nd Street U.S.A. or itams . 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify White Specify: Be Completed by 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed within the feath and Mental Hygiene. Itam 27 is marked other than Private Auto Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bennett Stine Louella Bradfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Good - Daughter 518 Butcher Valley Rd Rogersville TN 37857 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō permit. Pages Department of Important: If it eny injury or o 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2/20/2004 Brentwood, Maryland 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Funeral Service Licenses Miselin 3401 Bladensburg Rd Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final Physician disease or condition resulting in death) 10420 /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for it in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 1 Yes 2 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo Certification: To 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier + Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. c. mpletely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) veithin 2 29b. Signature and title of certifier 9c. License number 29d. Date signed (Month, Day, Year) 2004 30. Name and address of person ocompleted cause of death (Item 23a) (Type, Print) Ħ DOWIE 31. Date filed (Month, Day, 1)
FEB 2 4 State Registrar

			For State Registrar	State of Marylar		artment of Ho tificate of D			giene Reg. No. 20	004 07870
48	Physici		1. Decedent's Name (First, Middle, La Josephine Si					2. Date of De Month Februar	Day	3. Time of Death 2004 4:00 A ^M
	/Medic Examin		4a. Facility Name (If not institution, given Mariner Healt	e street and number)		4b. City, Town, or Bet1			4c. County	
	Funeral Director		579-44-9227	Gex 7. Age (In yrs 1 ☐ M 2 ☐ XF		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Nov. 1,	y, Year)	9. Birthplace (State or Foreign Country) South Carolina
	Maryland f show	ō	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 X Yes 2 ☐ No
	with the Page or 28e-	Funeral Director	Maryland Montg 10e. Street and Number 5721 Grosveno			Bethesda 10f. Zip Code	20814		10g. Citizen of V	Vhat Country?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Evaruhat must be notified at ODGe.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar t □ Yes 2 🏋 No		ecify Yes or No Rican, etc.)	14. Race Bfac	e - American Indian, k, White, etc.
21215-0036	within 72 hou iene." than "nature the Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th		(Give life. I	dent's Usual Occupa kind of work done d DO NOT use retired)	luring most of work	ing		esiness/Industry Private
land 2	uld be filed Aental Hygi rked other tlc event, I	To Be Co	17. Father's Name (First, Middle, Las Charles H.		<u> </u>		18. Mother's Name			98)
, Maryland	and 2 shousalth and No. 27 is ma		19a. Informant's Name/Relationship Jamilyaa Mahdi	- Daughter	28	ng Address <i>(Street a</i> 310 - 12th	n St., N.	E. Wash	., DC	20017
Baltimore,	Pages 1: ment of He ent: If iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Control	TUBILIONAL ILOUR STATE	shingto	sition (Name of natory or other Geogra on Nationa	al 2/26/		Suit1a	City or Town, State
Balt Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service Lice	Leway III		Name and Address	ning Rd.,	N.E. W	ash., Do	C 20019
8760,	Cate be executed /Medical Examiner the buriat-transit	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	prications that caused in each line. Parkinson Due to (or as a consection) Due to (or as a consection) Due to (or as a consection)	's Dise		, Such as cardiac (от гезриатогу аз	(est,	Approximate Interval Between Onset and Death
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Division of Vital	I or Attending Phy after death. Director: After thi I in by the funeral	ertification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not lead to determine to	(Month, Day Year)	Injury	Work M 1 □ Y	res 2 □No		Street and Number	er or Rural Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical Co	29a. Certifier (Check only one) 1X Certifying P 2 Medical Exa	hysicien: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death ation and/or inv	n occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the red at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
•	To the within To the compl	Me	29b. Signature and title of certifier	onBas,	On	29c. License	number 6 5 7 /			(Month, Dey, Year)
	34		30. Name and address of person who	Bao, M.D. 13	219 Exe	cutive Pa	rk Terra	ce, Ger	mantown	MD 20874
	Sta Regist		31. Date filed (Month, Day, Year) FFR 2 7 2004	32. Registrar's Sign	ature	e				

DHMH 17 Rev 1/2001

SOWENS, JOSEPHINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200 L; 07871 1- State Unpend Item#23a,27,28a-f,Per ME,C829,3/116/1968 Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 177, 2004 1437 P **Physician** Brian Sowell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1X M 2 □ F Months Days Hours Director 579-96-7404 31 July 27, 1972 Wash. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. Counts or 28a-f show the Medical Executive rount be notified at 1 XYes 2 No Director Maryland Prince George's District Heights 10e. Street and Number 10g. Citizen of What Country? 238 8107 Redview Drive 20747 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 🏋 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies important: if Item 27 is marked other tt
any injury or other traumatic event. III.a. 12th Recycle Paper Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Curly Sowell Bonnie Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Spriggs - Mother 8107 Redview Dr., District Heights, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Lee's Crematory 3/2/2004 Clinton, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Narcotic Intoxication Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. B 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗋 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed 1X Yes 2□ No Division of Vital Hospital or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🛱 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 No 2 No this foundry 1:30pM 28a. Date of Injury **Toutive** *nth, Day Year)* **2/17/04** 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural unknown after death. 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Found at home** 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 18701 Roxbury Rd, Hagerstown, MD 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) * Additional Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 18, 2004 O.C.M.E. Maryland 21201

State Registrar

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31. Date filed (Month, Day, Year,

ORIGINAL

		1	State of Maryland / Dep State of Maryland / Dep For State Of Maryland / Dep	artment of Health and Mertificate of Death	lental Hygien	- Z 11 1 1 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1
			Decedent's Name (First, Middle, Last)		2. Date of Death Month D	3. Time of Death
в	Physicia		Marcia Mae Trimble		February	
	/Medic Examin		4a. Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			1005 Leafy Hollow Circle	Mt. Airy		Frederick
	Funeral Director	:	5. Social Security Number 216-88-1530 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 42 Yrs.	If Under 1 Year	8. Date of Birth (Month, Day, Yea NOV. 26, 19	9. Birthplace (State or Foreign Country) 961 Indiana
	P >	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	ehov ehov	. 1	Maryland Frederick Mount	Airy		1∑Yes 2☐No
	28a-1	5	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	Se or	<u></u>	1005 Leafy Hollow Circle	21771	Uni	ted States
	ms 2:	era		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if Item 27 is marked other then "netural", or Items 23a or 28a-f show ship injury or other traumatic event, the Madical Examinar motal to nutified at once.	Completed by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 M No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	rican, etc.)	Black, White, etc. Specify: White
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Maryland	ntal H ed oth	Be	17. Father's Name (First, Middle, Last) James Robert Routson	Carol	Hens :	
7	d Mer marke	၉ .		ling Address (Street and Number or Rur		
Ma	id 2 s ith an 27 is i			5 Leafy Hollow Cr.	/ Mount Ai	rv. MD 21771
ē,	Heal Heal	Ī	20a. Method of Disposition 20b. Place of Disposition			Location - City or Town, Stete
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altimore,	partm porta y inju	1		22. Name and Address of Facility Sta		
Ö	Depa Impo eny ir		Baymond Celerson	8 E. Ridgeville Bl	vd./ Mount	
	Physician		23a. Pert1. Enter the disease, or complications that caused the death. Do not established for the disease or each line. Immediate Cause (Final disease or condition.		or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical		resulting in death) Due to (or as e consequence of):			
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n	Jing Pt. After th funeral	on:	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) 1 Annual 5 Pending (Month, Day Year) 28b. Time	Work?	28d. Describe how in	jury occurred
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Div	tal or Atten rs after deat al Director: ed in by the	Certification;	4 Homicide determined 200. Place of Injury Actionic, family, building, etc. (Specify)	silest, factory, office	City or Town, St.	ate)
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu-	and due to the cause red at the time, date a	r(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature we title of certifier	29c. License number (3) 3/76/		Date signed (Month, Day, Year) 2 / 18/64
	8		30. Name and address of person who completed cause of denth (Item 23a) (Type BRIAN M, O'CONNER MD 50)	e, Print) W. SEVENTH ST.	FREDER!	CK MD 21701
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 19 2004 32. Registrar's Signature	Print) W. SEVENTH ST.		,

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar 07873 Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Feb 14 2004 5:28am C. Taylor /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Mercy Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 3m 2 F Yrs. 218-80-7481 43 Feb. 18, 1960 **Director** Maryland Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or Iteme 23a or 28a-f show traumatic event, the Modical Examinar must be notified at MD Anne Arundel Severna Park 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Enclave Trail 21146 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel, or Iten any injury or other traumatic event, the Medical Examinar, page. 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complete Institutional College (1-4or 5+) Elementary/Secondary (0-12) Pharmacy Pharmacist 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon C. Taylor Pat Rommel 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat R. Taylor/Mother 501 Enclave Trail Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baldwin UMC Cemetery 20a. Method of Disposition February 19, 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 Millersville, MD * 4 ☐ Donation 5 ☐ Other (Specify) P.A. Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. 21. Signature of Funeral Service Licensee Severna Park Funeral H Severna Park, 10 2114 Home Severna Approximate Interval Between Onset and Death 23a. Pyr11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) -ibrowatesis thdomina **Physician** /Medical Due to (or as a consequence of): Examiner Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 2000 3 Probably 4 Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ this Director: After the 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number Drugyy 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print) ELDMAN

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month,

Day, Year)

2004

FEB 1 9

	For State Registrar	State of Maryland	•	rtificate of		R	_{eg. No.} 20	04 0787
	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
ian cal	Fred Harold Talbe			4h City Town	r Location of Deal	FEBRUARY	Y 1 2	004 7:52 p
ner	4a. Fecility Name (If not institution, give s					ш	St. Ma	- CA
	St. Mary's Hospita 5. Social Security Number 6. Sex		ist birthday)	Leonardi ff Under 1 Year	If Under 24 Hrs	8. Date of Birth		9. Birthplece (State or Fore Country)
		M 2□F 9	3 Yrs.	Months Days	Hours Min.			Arkansas
	Usual Residence of Decedent	100 Cit.	Town and a					10d. Inside City Lim
_	10a. State 10b. County	Toc. City,	Town or Lo	ocation				1 🗆 Yes 2 🕏
Director	Maryland St. Mary 10e. Street and Number	s Lexi	ngton	Park 10f. Zip Code		1	0g. Citizen of Wi	hal Country?
				20653			USA	,
Funeral	20493 Partins Lane	2. Was Decedent Ever in U.S	S. 13.		lispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race	- Americen Indian,
Fun	1 Never Married 2 Married	Armed Forces? 1 RYes 2 No 194 If Yes, Give 104	2-	If Yes, specify Cub 1 ☐ Yes 2 Ro		to Hican, etc.)		, White, etc.
l by	3 ₩ Widowed 4 Divorced	Year or Dates: 194	4	TO THE ZEE NO	эрөспу:		Specify:	Black
Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most of wo	orking	16b. Kind of Bus	siness/Industry
Idm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	,		HC Corr	ernment
	11th 17. Father's Name (First, Middle, Last)		ва	ttery Te		me (First, Middle, I		
9 Be	Green Winston Tal	hert			Willie	e Daisy H	arrison	
10	19a. Informani's Name/Relationship (Ty)		19b. Mailii	ng Address (Street	<u> </u>	ural Route Number		State, Zip Code)
	Janice Walthour /	Daughter	2049	3 Partin	s Lane,	Lexington	Park, 1	MD 20653
	20a. Method of Disposition		ace of Dispo	osition (Name of matory or other pla	ce)	Date	20c. Location - C	City or Town, Stete
	1 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State	. Geor			6/2004 V	alley L	ee, Maryland
	21. Signature of Funeral Service License		. 22	2. Name and Addre				Home, P.A.
	Manu Ki	220 1/1011						MD 20650
	23a. Part1. Enter the disease, or compliant shock, or heart failure. Ust only on	cations that caused the death.	. Do not ent	ter the mode of dy	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
	fmmediate Cause (Final disease or condition	CONSON	an	y A	of for	usea	20	Onset and Death
	resulting in death)	Due to (or as a consequ	ence of):	J	100			190
	Sequentially list conditions,	Due to (or as a consequ	191	ten	Dan			17191
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a correlated	price or).					
xan	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
calE								
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnar		⊒Ectopic pregnanc				of defivery
lcla	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of de		Other (specify)	у		Mon	th Day Year
hys	9 Unknown							
by F	Part II. Other significant conditions con	stributing to death but not resu	Iting in the u	inderlying cause gr	ven in Part I.			bute to the cause of death?
ted						1 🗆 Yo	es 2 marino .	3 Probably 4 Unkno
Completed						24a. Was a autops	sy pr	fere autopsy findings availation to completion of cause
Co			_			perform 1 Yes		eath? ☐ Yes 2 ☐ No
Be	25. Was case referred to medical examiner?	lospital:		/ 0#	ner:	eath (Check only on		
- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2 t	ER/Outpatie 28b. Time o	IN SIM DOA	4 Iquising	Home 5 Reside	ence 6 Othe ow injury occurre	
lon	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk?]Yes 2 ☐ No	Edd. Bederibe in	ow many occurre	
Certification:	3 Suicide 6 Could not be	28e. Place of fniury - At ho	me, farm, st			28f. Location (St	treet and Numbe	r or Rural Route Number,
erti	4 ☐ Homicide determined	building, etc. (Specify)			City or Town	n, State)	
alc	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	wledge, deat ion and/or in	th occurred at the tinvestigation, in my	me, date and plac opinion, death occ	ee, and due to the courred at the time, d	ause(s) and man late and place, a	ner as stated. nd due to the cause(s)
양		- 11/-		29c. Licen	se number	2	9d. Date signed	(Month, Day, Year)
Medical	29b. Signature and title of certifier							
Medic	29b. Signature and title of certifier	8415	_	D33	3470		2/3	104
Medic	30. Name and address of person who co	ompleted cause of death (Item	23a) (Type		3470		2 3	104

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

FRED HAROLD TALBERT

			1 - State Registrar	State of Maryland / Depa	artment of Health and Natificate of Death	Reg. I	ne No. 2004	3. Time of Death
	Physicia /Medic		1. Decedent's Neme (First, Middle, Last) Aston Burton Tro			Feb 12, 2	Day Year 2004 4c. County of Death	2:56 P M
	Examin	er	4a. Fecility Neme (If not institution, give sti Fort Washington Ho		4b. City, Town, or Location of Death Fort Washington		Prince G	
	Funeral Director		5. Social Security Number 6. Sex 578 14 7952	7. Age (In yrs. last birthday) 2 F 87 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea June 23,	9. Birth Cou 1916 Nort	place (State or Foreign intry) ch Carolina
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Mexical Examinet must be notified at once.	To Be Completed by Funeral Director	Usuel Residence of Decedent 10a. State 10b. County Maryland Charles 10e. Street and Number 6980 Heather 11. Marital Status 1 Never Married 3 Widowed 4 Divorced (Specify only highest grade Elementary/Secondary (0-12) 8th 17. Father's Name (First, Middle, Last) William J. Trollin 19a. Informant's Name/Relationship (Typ Ida Trollinger (WI) 20a. Method of Disposition 1 Pedrial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	Drive 2. Was Decedent Ever in U.S. Armed Forces? 1	Vansroad 10f. Zip Code 20616 Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerts 1 Yes, Specify Cuban, Mexican, Puerts A X X Specify: dent's Usual Occupation	wing Interpretation of the property of the pro	Citizen of What Counited Stat 14. Race - Ameri Black, White, Specify: 15. Kind of Business/Ir 16. R. Transfen Sumame) 27. Eries Maryland 16. Location - City or Taitland, Maryland	tes ican Indian, etc. White industry sportation p Code) 20616 Town, State Maryland
Ball	Permit. Depart. Medical Examiner		23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not ende cause on each line. Arteriosclerotic Due to (or as a consequence of):	2. Name and Address of Facility Lee Alexandria Ferry F ter the mode of dying, such as cardiac Cardiovascular	Road, Clint or respiratory arrest,	on. Maryl	6633 Old and 20735 Approximate Interval Between Onset and Death Years
68760,	eath certificate be executed attending physician and for use as the buriat-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
.O. Box 6	the death certifica y the attending ph iched for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delin Month	v <i>e</i> ry Day Year
٥.	res that the designed by the a	by	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to	the cause of death?
Il Records,	The law requi ale has been s page 2 should	Completed				24a. Was an autopsy performed 1 Yes 2 5	24b. Were aut prior to c death?	topsy findings available completion of cause of
Vital	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ ₩o H	ospital: 1 ☐ Inpatient	Other	ath (Check only one)_ Home 5 - Residence	e 6 ∏Other (Spec	:ifv)
o	ding Phys h. Atter this funeral di	H-	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how i		y)
Division	il or Attending after death. I Director: Afte d in by the fune	Certification:	1 🕅 Natural 5 Pending 2 Accident investigation 3 Suicide 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Stree City or Town, S	it and Number or Ru itate)	ral Route Number,
_	Hospite 4 hours unerel	Medical C	29a. Certifier XXCertifying Phys (Check only one) 2 Medical Examin	sicien: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	oth occurred at the time, date and place nvestigation, in my opinion, death occurred	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2. To the Complete	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month	15
(- 1	BW2			impleted cause of death (Item 23a) (Type 12070 Old Line Cet		ryland 2060	9.5	2004
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1			

DHMH 17 Rev 1/2001

ORIGINAL

		State of Maryland / Department of Health and M		e o o o :	
	•	For State Certificate of Death Registrar	Reg. N	/ HH lt	07876
Physici	on.	Decedent's Name (First, Middle, Last)	2. Date of Death Month D	ay Year	3. Time of Death
/Medi	cal	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	FEB. 22	2 2004 lc. County of Death	1810 M
Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PENINSULA REGISAAL MODIEN CINTUS SAUSHULA		Nicom	100
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp	nlace (State or Foreign
Director		2 13 - 62 - 9823 190 2 F 50 Yrs. World State 190	7-20-5	53 U	7
yland yland		10a. State 10b. County 10c. City, Town or Location		1	0d. tnside City Limits 1 Yes 2 No
death with the Maryland ons 23s or 28s-1 show rinks the reditional to reditional the reditional to the	Funeral Director	10e, Street and Number 10f. Zip Code	100.0	Citizen of What Cour	//
with t	I DI	11363 Brockett Sayar 21853	109.	1.50	
3-6 3 er death wi	inera	11. Maritat Status 12. Was Decetient Ever in U.S. Armed Ferces? 13. Was Decedent of Hispanic Origin? (Spe fryes, specify Cuban, Mexican, Puerto in U.S.)	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	can Indian, etc.
336 Is atte	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:		Specify: R	1-1-
21215-0036 d within 72 hours after death w jens. or than "natural", or flems 23a tra Medical Examires must	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working)	ng 16b.	Kind of Business/In	dustry
/oc/	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)	1	1	17.
filed 2	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maide	en Sumame)	1-1-em
H. Tayllard 21 aryland 21 s should be filed wi and Mental Hygien is marked other th	To B	Harold James Taylor Incz	mac 1) runner	Vd
	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	al Route Number, City	or Town, State, Zip	Code)
Ore, North of Health	1 8	20a, Mietriod de Disposition	Date 20c.	Location - Oity or To	own, State
imor Pages Hent of Innt: If its		1 Burial 2 Demation 3 Removal from State 14 Donation 5 Other (Specify) Mace dowing Mean, Park 2-28	-04 W	estover	md.
Baltimore, N permit. Pages 1 and Department of Health Important: If item 27 any nijury or other tr once.	1	21. Signature of Euneral Service Licensee 22. Name and Address of Facility Be.	unic Smi.	th funero	1 Home
20289		23a. Part1. Enter the disease, accomplications that caused the death. Do not enter the mode of dying, such as cardiac cashock, or hear failure. List only one cause on each line.	or respiratory arrest,	it 4, md	Approximate
Physician	ı	Immediate Cause (Final			Interval Between Onset and Death
/Medical	ı	disease or condition resulting in death) a. Due to (vr as a consequence of):			
Examiner	<u>.</u>	Sequentially list conditions, if any leading to immediate b. AS IVA ON I CUMON (C. Due to (or as a consequency of):			
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that infriated events c.			
760, te be executed ysician and e burial-transit		resulting in death) Last Due to (or as a consequence of):			
6876 tificate b ng physic as the b	dlcal	d			
Box 6 eath certif	n/Me	IF FEMALE: 23b. Was decedent pregnant 1		23d. Date of delive	
IS, P.O. BOX 687 res that the death certificate igned by the attending phys be detached for use as the	Completed by Physician/Medi	in the past 12 months? 1		Month	Day Year
P.O. that the de ed by the detached	Phy	Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
Division of Vital Records, to Attending Physician: The law requires tafer death. Director: Alter this certificate has been signed in by the funeral director, page 2 should be on the control of the con	ed by	small bounds obstrict ion	1 🗆 Yes	2 ØNo 3 ☐ Prob	pably 4 Unknown
ecord law requir as been si	plet	metastatic carcinomatosis	24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
al Re			performed?	death?	2 No
f Vital F ystcian: Th ystcian: Th director, pag	To Be	examiner? Hospitat Other	n (Check only one) me 5 ☐ Residence	6 □Other (Specif	(v)
On of ding Phys n. After this funeral di			28d. Describe how in		,,
rision Attendia death. ctor: Ay y the fu	icatle	2 Accident Investigation M 1 Yes 2 No	28f. Location (Street	and Number or Pur	al Pouta Number
Divi	Certification:	3 Suicide Coura not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Sta	ate)	17 7 Gdio 7451115-07,
Division of Vital Records, P.O. Box 687 To the Hos vital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the tuneral director, page 2 should be detached for use as the	edical C	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.			
the H thin 24 the F mplets	Medi	one) and manner stated. 29b. Signardre and title of offitiger 29c. License number		Date signed (Month,	
- F. 2 F. 3		10 Cal Visulo 40059368		2/23/04	
SAULKA TAIL		30. Name 🐋 address a person who completed cause of death (Item 23a) (Type, Print)		, , , , ,	
C.H.4		31. Date filed (Monty: Pay Year) 5 200 32. Segistrar's Signature	2504		
Si Regis	tate trar	31. Date filed (Month, Pan Year) 5 2004 32. Segistrar's Signature			

B.K.S UNKNOWN 04-041 State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 200 L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** FEB. A M 2004 Jose Alfonso Solano Torres 0301 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NEW HAMPSHIRE AVENUE @ MERWOOD DRIVE TAKOMA PARK MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Mexico 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Year Days Hours 11M M 2□ F 22 1-08-1982 Director none Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at D.C. Washington, D.C. 1X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4120 14th Street N.W. #33 20011 Mexico 238 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married ö altimore, Maryland 21215-0036 1⊠Yes 2□No Specify: Mexican White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Window Cleaner Window Cleaning 6 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Ana Maria Torres 1 and 2 should be Conrado Solano Gallote 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 RafaEL Contorral/Friend 4120 14th St.N.W. Washington, D.C. 20011 other 20b. Place of Disposition (Name of Date 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Cemeterio El Palmer 2/21/02 Veracruz, Mexico þ * 4 □Donation, 5 □ Other (Specify) 21. Signature Funeral Service Lice PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** HULTIPLE INTRIES resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, and leading to invalid a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, Completed by Physiclan/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No 24a. Was an page 2 autopsy performed? certificate 12 Xes 2 🗆 No of Vital Physicien: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) AT SCENE Hospital: 1XYes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Attending Division 5 Pending investigation OCCUPANT OF LAR 1 Natural 2:59 AM death. 218/04 1 ☐ Yes 2 XNo 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital or NEWHAMPSHIRE & TERWOOD DR ROAD 24 hours a pellij TAKONA PARK, HI) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintened to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho
To the Fune
completely f (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E FEB. 8, 2004 (Med 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BNA RUBIO MO 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month EB 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** FEBRUARY 10, 2.004 **GERTRUDE** 8:00 /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5600 WISCONSIN AVENUE, # 806 CHEVY CHASE MONTGOMERY 8. Date of Birth (Month, Day, Year) OCT. 19, 1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** Days 1□M 2□F 514-38-6020 83 1920 AUSTRÍA Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show the Medical Examiner must be notified at fy□Yes 2□No MARYLAND MONTGOMERY CHEVY CHASE Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 5600 WISCONSIN AVENUE, APT. 806 U. S. A. death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or itemility or other traumatic event, the Medical Examina. 1 ☐ Yes 21 No If Yes, Give The Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 5+ PHYSICIAN MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BARBARA STEFFL GEORG HOLLWARTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCIA M. ALLEN _ FRIEND 4800 CALVERT STREET, N. W., WASHINGTON, D. C. 20007 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State permit. Page Department of Important: if any injury or once. NATIONAL CREMATORY 2/16/2004 FALLS CHURCH, VIRGINIA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service L EDWARD SAGEL FUNERAL DIRECTION, INC. Donald 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC DYSRHYTHMIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): use as the burial-P.O. Box 68760. the attending physician IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ page 2 should be BLADDER CANCER ¥E Yes 2 No 3 Probably 4 Unknown Be Completed SMOKING, HYPERTENSION, HYPERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2¹² No certificate 1 ☐ Yes Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 TResidence 6 Other (Specify) Medical Certification: To 1 Yes 2 □ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 X Natural 5 Pending To the mosphers after death.
within 24 hours after death.
To the Funeral Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 12 D0014107 MD FEBRUARY 12, 2004 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) BRYAN ARLING, M. D. 2440 M. STREET, N. W., # 817, WASHINGTON, D. C. 20037 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 17 2004 Registrar

			1 - For State Registrar	State of M	f aryland		artment rtificate			and M	lental Hy	giene Reg. No	200	L 0787
		ш	1. Decedent's Name (First, Middle, Las	st)							2. Date of De			3. Time of Death
	Physici /Medio		FREDDIE	DUNMAN		TEAGU	Е			3	FEB.21			2:19 PM M
	Examir	er	4a. Facility Name (If not institution, give		7)		- "		Location o	f Death		4c.	County of Dea	ath
			6015 MASSACHUSET		// /		B If Under	ETHE	SDA If Under 2	04 Hrs	0.0		MONTGON	
h	Funeral Director		5. Social Security Number 6. S 220.52.4921	9X □ M 2(X)F	93	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi	7 91°C) ARK	thplace (State or Foreign SURTO) ANSAS
	ס		Usual Residence of Decedent											
	ırylan how	_	MD 10b. County MONTGOME	D. 3.7		, Town or Lo								10d. Inside City Limits
	8e-f	Director		KI	<u> </u>	BETHES	1							1 □ Yes 2√No
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow he Madical Examiner must be notified at		10e. Street and Number 6015 MASSACHUSET	TC AVENUE			10f. Zip					-	izen of What C	ountry?
	s 234	Funerai	11. Marital Status	12. Was Deceden		S 12 V	208		connic Orec	nin? /Co.	ecify Yes or No		U.S.A.	oriena ladina
10	fter d	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces	?		f Yes, spec	fy Cubai	n, Mexican	, Puerto	Rican, etc.)		Black, Whi	
930	al', o	ğ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	X No	Specify:				Specify: WI	HITE
Maryland 21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	ient's Usua kind of won	Occupa	ition	of worki	ina	16b. Ki	ind of Business	/Industry
2	ithin han Mar	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT us	retired)			9			
2	lied v Hygie ther th		17. Father's Name (First, Middle, Last)		1	Н	OMEMA:	KEK	19 Motho	r's Name	First, Middle		WN HOME	
and	d be f	9 Be	JOHN O. DUNM	AN							JENNING		Surrame)	
2	should nd Me mark mati	은	19a, Informant's Name/Relationship (1	Type, Print)		19b. Mailin	a Address	Street a					r Town, State,	Zin Code)
S	nd 2 suith ar 27 is r trau		JILL COCHRAN/DAI	JGHTER							E NW WD	4 100		L.P 0000)
re,	s 1 a f Hea item othe	13	20a. Method of Disposition			ace of Dispo	sition (Nam	e of			Date WD		cation - City or	Town, State
Ë	Page nent c		1 🗗 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify			INGTON				IARCH	1,200	4 AR	LINGTON	, VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28e-f ehow amounts to the reaumatic event, the Modical Examiner must be notified at ance.		21. Signature of Funeral Sovice Colon	7/1	3/2						EPH GAW IUE NW		S SONS,	INC.
-3	-0-		23a. Part 1. Enter the disease, or companies shock, or heart failure. List only	olications that cause	ed the death								20010	Approximate
	Physician		Immediate Cadse (Final											Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. CONGE:	SIIVE sa consequ	HEART	FALL	JRE,	END	STAG	E			
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8760,	cate be executed physician and the burial-transit	aiE		Due to (or as	s a consequ	erice or).								
687	phys phys s the	edicai	•	d								·		
Box (death certific e attending pl d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	23d. Date of de	livery
	s that the death ned by the atter e detached for u	icia	in the past 12 months? 1 ☐ Yes 2 ☐ XNo	1 ☐ Live birth 4 ☐ Pregnant a			lEctopic pre Other (spe						Month	Day Year
P.O.		hys	9 Unknown	9⊡ Unknown										
Ś	0 00	by F	Part II. Other significant conditions of MULTI-INFARCT DEM	ontributing to death l	but not resul	Iting in the ur	iderlying ca	use give	n in Part I.		23e. Did t	obacco u	se contribute to	the cause of death?
ord	w require been sig should b	ted									10	Yes 2]No 3 ☐ Pi	obably 4XXUnknown
Vital Record	has b	Completed									24a. Was autor	osy	prior to	itopsy findings available completion of cause of
ᇤ	The											rmed? 2⊠ No	death? 1 ☐ Yes	2 🗆 No
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of	Phys r this rat di	1: To	1 ☐ Yes 2 💢 No 27. Manner of Death	1 ∐ Inpati 28a. Date of Inju		R/Outpatient 28b. Time of			4 🗀 Nut		ne 5 🗌 Resi		Other (Spe	cify)
Division	Attending in death. • ctor: After by the funer	tio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury	М	c. Injury Work' 1 Y	? es 2 □ N				, , , , , , , , , , , , , , , , , , , ,	
Vis	Attended ector	ifica	3 Suicide 6 Could not be determined	286. Place of in	jury - At hor	ne, farm, stre	et, factory,	office		2				ural Route Number,
Ö	tal or	Certification:	- I Homolog	bullding, e	tc."(Specify)						City or Tov	vn, State)		
	To the Hospital or Attending Physician: The law within 24 burns after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best iner: On the basis of and manner si	of examination	rledge, death on and/or inv	occurred a estigation, i	the time	e, date and nion, death	place, a	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	•	•		29c.	License	number			29d. Date	e signed (Mont	h, Day, Year)
	1		1 Seconi	W	7	7		D3	5579			FER	.23,200	14
	1>		30. Name and address of person who concerns the concerns										• 23 , 200	·¬
			SUSAN MILLER, M.D 31. Date filed (Month, Day, Year)		TULIP rar's Signatu	HILL	TERRA	CE	BETHE	ESDA,	MD 20	816		
	Sta Registr		FEB 2 5 20		rar s Signati	B	100	Ma	/					

		1	For State Registrar	State of M	aryland	d / Depa <i>Cei</i>	artmen tificate	t of H	ealth a	and M		110g. 110.	200		07880
	Physicia		Decedent's Name (First, Middle, Last								2. Date of De Month Feb. 2	Day	2004 ^{Yee}	r	Time of Death
Н	/Medic	al	John J. Ti 4a. Facility Name (If not institution, give	erney			Ah City	Town or	Location of	of Death	reb. Z		County of De		1:20 A "
П	Examin	er	4a. Facility Name (If not institution, give 8000 Springer Ro					ethe) Douth			ontgom		
-	Funeral		5. Social Security Number 6. S	ex 7. Ag	ge (In yrs. la	ast birthday)	If Under	1 Year	If Under	24 Hrs. Min.	8. Date of Big	th	9.8	irthplece	(State or Foreign
П	Director		155-22-9224	∆ M 2□F	71	Yrs.	Months	Days	Hours	IVIII1,	June I	7,19	32 Ne	w Je	rsey
	p .	-	Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d.	Inside City Limits
	faryia shov	5		0.201	,		ethes	da							T√ Yes 2 No
	the N	Director	Maryland Montgom 10e. Street and Number	ету	1		10f. Zip					10g. Citiz	zen of What	Country?	}
	filed within 72 hours after death with the Maryland Hyglen. Ither than "natural", or Items 23s or 28e-f show ant, the Medical Examinal medical collified at	0	8000 Springer Ro	ad				2081	.7				U.S.A	. •	
	death	Funeral	11, Marital Status	12. Was Decedent Armed Forces		S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spo	ecify Yes or No Rican, etc.))- 1	4. Race - Ar Black, W		Indian,
9	or Ite	F	1 Never Married 2 Married	1X Yes 2 ☐ If Yes, Give Year or Dates:	1954-	ł	1□Yes				,	-	Specify:		
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7	in 72 "nat	Completed	(Specify only highest gra	ide completed)	5.)	(Give	kind of wor	rk done d se retired	luring mos	t of work	ing	100.11	TO ST BUSINESS	,	,,,,
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פ	e filec al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last,	,							e (First, Middle		Sumame)		
Jai	Menta Menta arked	2	John J. Tierney								ret Mc				
Mar	nd 2 shouth and 27 is my		19a. Informant's Name/Relationship (Mary Ann Tierney/								thesda,				de)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendle Hyglene. Importent: If item 27 is marked other than "natural; or items 20a or 28e-f show among high properties of the unalice event, the Medical Examinat meat be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3		, ,	lace of Dispo				Feb.			cation - City		
Ë	rtmer rtent		* 4 □ Donation 5 □ Other (Specification 21. Signature of Fundal Service Licentation 21.		Gat	e of F				2004 ⊳ DeV	ol Fune	Silv	er Spr Home	ing,	, Md.
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B			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death line.	n. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory a	rrest,		Int	pproximate lerval Between nset and Death
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× 68	ertific ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregna	ncv							23d. Date of	delivery	
Вох	attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal	death 3	Ectopic pr					2	Month	Da	y Year
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٥.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as It	by Pł	Part II. Dther significant conditions	contributing to death	but not rest	ulting in the u	inderlying o	ause give	en in Part I	l.	23a. Did	tobacco u	se contribute	to the c	ause of death?
rds	w require been sig should b	ed	Hypertension						-		1 🗆	Yes 2[□No 3□	Probably	y 4 ⊠Unknown
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nc	Jing After fune	tion	1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D.	ay Year)	Injury	M	28c. Injun Worl	k? Yes 2 □	No	204. 0030.100	riow injur	, 00001100		
Division	l or Attending after death. Director: Atte I in by the fune	ertification;	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of Ir	njury - At ho etc. <i>(Specif</i>)	ome, farm, st					28f. Location City or To	Street and		Rural Ro	oute Number,
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	the I	Med	one) 29b. Signature and title of cegifier	and manner s	stated.		290	c. Licens	e number			29d. Dat	e signed (Mo	onth, Day	y, Year)
	P P P		Packet 6	Vactoria.		M.D			ES-00	0			uary :		
-	20		30. Name and address of person who	completed cause of	death (Item										
			Rachel Hartman,	M.D., John	ns Hop	okins	Hospi	ta1	600 N	North	wolfe	St.,	Balt.	, Md	. 21287
93	St	ate	31. Date filed (Month, Day, Year)	//-	trar's Signa	iture &	Se	Ca No	1/						

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State of Maryland / Department of Health and Mental Hygiene 2004	0.
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			1 - For State Registrar	Olalo of I	viarytaria / C	Certificate of	Death		Reg. No.	4 0/881
	Dhusia		1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea	ath Dey Year	3. Time of Death
	Physici /Media		Catalina Trejo					Februar	y 14, 2004	20:23 P M
	Examir	er	4a. Facility Name (If not institution			1	or Location of Death		4c. County of De	
	-		Montgomery Gene 5. Social Security Number		Age (In yrs. last birtho	Olney Av) If Under 1 Year	r If Under 24 Hrs.	8. Date of Birt	Montgome	
tie	Funeral Director		577-82-0682 Usual Residence of Decedent	1□ M 2XF	76 Yr	Months Days		8. Date of Birt (Month, Da) Feb. 14	, 1928 E1	rthplace (State or Foreign Sountry) Salvadore
	yland yland		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	death with the Maryland ms 23e or 28e-f ehow	ctor	Maryland Montgo	omery	Rockvill	e				1X Yes 2 No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	ath w	ral	13414 Parkland		4	20853			USA	
99	after de or Items	y Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Deceder Armed Force 1 Tyes 2 If Yes, Give	XI No		Hispanic Origin? (Sp ban, Mexican, Puerto Specify:E1 S		14. Race - Am Black, Wh ian Specify: W	ite, etc.
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75	in 72	Completed	(Specify only higher	t's Education st grade completed)	(0)	ecedent's Usual Occu Give kind of work done fe. DO NOT use retin	during most of work	ing	16b. Kind of Busines	s/industry
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<u> </u>	Menta Menta arked aric e	To	Juan Pablo Pine	da			Delfina O	rellala		
, Maryland 21215-0036	and 2 sho lalth and 127 le ma gr trauma		19a. Informant's Name/Relations Ana Ruth Trejo-						r, City or Town, State, MD 20853	Zip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "naturel", or items 23e or 28e'f ehow are not into a proper in the marked other than "naturel", or items 23e or 28e'f ehow in injury or other traumatic event, the Madical Exportment and be notified at another.		20a. Method of Disposition 1 □XBurial 2 □ Cremation 4 □ Donation 5 □ Other (S		te cemetery.	isposition (Name of crematory or other pla d Nat [†] 1 Ce	ace)	Date /2004]	20c. Location - City o	r Town, State
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service	Licensee		22. Name and Addr	ess of Facility Hin	es-Rina	ldi Funera	1 Home g, MD 20904
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death. Do not				<u> </u>	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	only one cause on each	Pneumoni	a				Onset and Death 10 Days
	/Medical		resulting in death)	Due to (or	as a consequence of)					
E	Examiner		Sequentially list conditions.	b						
	pe sit	inei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of):					
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687	ificate g phy as the	Medicai		0.						
O. Box	ath ce attendi for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death at time of death	3 Ectopic pregnand 5 Other (specify)	су		23d. Date of de Month	olivery Day Year
۵.	that the poly detail		Part II. Other significant condition	ons contributing to deat	n but not resulting in th	e underlying cause g	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rds	w requires that the de been signed by the should be detached	q pa	Sepsis, Respira	tory Failu	re, Renal	Failure		1 🗆 Y	es 2□No 3□P	robably 4X\u00e4Unknown
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a	in: Th	မ လ	25. Was case referred to medical				00 Pl (P	1 ☐ Yes	2X No 1 □ Ye	s 2 No
S	Physicien: this certific ral director,	To Be	examiner?	Hospital:	atient 2 ER/Outpa	itient 3 DOA Ot	26. Place of Death		ence 6 □Other (Spe	acifu)
o uc	fing Phy n. After this funeral o	lon; T	27. Manner of Death 1 X Natural 5 ☐ Pendin	28a. Date of I (Month,		e of 28c. Inju	iry at ork?		ow injury occurred	scriy)
isio	Attending r death. ector: After y the fune	ficat	2 Accident investig	not be 200 Place of	Injury - At home, farm		Yes 2 No	28f. Location (S	treet and Number or R	ural Route Number
Div	al or A s after il Dire	Certification;	4 Homicide determ	building,	etc. (Specify)	ones, raciory, omco		City or Tow		oral Floato (Valligo),
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) Certifyin 2 Medicel	g Physician: To the be Exeminer: On the basis and manner	s of examination and/o	eath occurred at the t r investigation, in my	ime, date and place, opinion, death occurr	and due to the c	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifie			29c. Licen	se number	2	29d. Date signed (Mon	th, Day, Year)
	3		Dr. France k	line - Moure	Corc	Doos	8542	T	FEB. 16 20	004
	U		30. Name and address of person			pe, Print)			•	
	<u> </u>		Libuse Heinz-Mo			Prince Ph	nilip Dr.	01ney, 1	MD 20832	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 5		strar's Signature	Spark	2/			

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			1 - State Registrar AMEND#8perFH2	State of M	iarylan McCo		artmen				lental Hy			004	0.7	882
	Physici		Decedent's Name (First, Middle, La.	st)							2. Date of D Month	eath D	ay	Year		of Death
>	/Medic Examir		4a. Facility Name (If not institution, given Shady Grove Adve)	-		Town, or	Location of	of Death	02	4	c. Count	2004 by of Death gomer		
e,	Funeral Director		5. Social Security Number 6. S 220-50-8442 1 Usual Residence of Decedent	6ex 7. A □ M 2 🗓 F	ge (In yrs. 56	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth Jur 9, 1	ne .947	9. Birth Coul Wash	olace (State ntry) ingto:	or Foreign
	the Maryland 28a-f show	ector	10a. State 10b. County Md. Montgom 10e. Street and Number	ery		y, Town or Lo	cation	Codo				10= 0		What Cour		City Limits
	3a or	Dir	15800 Buena Vista	Drive				855						State	•	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural" or Items 23a or 28a-f ahow many injury or other treumatic event, I're Medical Examiner must be multiled at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 K If Yes, Give Year or Dates:	?	'		lent of Hi		gin? (Spe n, Puerto	ecify Yes or N Rican, etc.)		14. Ra Bla	ce - Americack, White,	can Indian, etc.	n
1215-0	within 72 ho ane. Ihan "natur	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+)	life. L	kind of wor DO NOT us	k done d e retired	during mosi)	t of work	ing			Business/In		
Maryland 21215-0036	uld be filed v Aental Hygie rked other t tic event, In	To Be Co	17. Father's Name (First, Middle, Last) Mark Wilson Gray			Day C	are r	rovi	18. Mothe		e (First, Middle	, Maidei	n Sumar	care me)		
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Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licer	Deep		L	0 Eas	t De	er Pa	ırk I	/ol Fun Or. Gai	ther	Horsbu:	me rg, M	d. 20	877
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8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as												
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Ω.	w requires that the been signed by should be detact	by	Part II. Other significant conditions of	ontributing to death I	but not resu	ulting in the un	nderlying ca	iuse give	n in Part I.				_		e cause of	
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Ž	ysician: iis certifica director, j	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ant 2 🗀	ER/Outpatient	3 DO	Othe			(Check only		a Class	(0		
ion of	ding Pt h. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a Date of Inju (Month, Da	ury	28b. Time of Injury		c. Injury Work		2	ne 5 Resi 28d. Describe				7	
Divis		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of in	jury - At ho tc. (Specify	me, farm, stre	et, factory,	office		2	28f. Location (City or To	Street ar wn, State	nd Numb e)	er or Rura	Route Nur	mber,
	To the Hospital or within 24 hours afte to the Funerel Dir completely filled in	edical	one)	ysician: To the best niner: On the basis of and manner st	or examinat	wledge, death ion and/or inv	estigation,	in my op	inion, deat	d place, a	and due to the ed at the time,	cause(s date and) and ma d place,	anner as st and due to	ated. the cause((s)
-	To the To the Comple	Σ	29b. Signature and title of certifier Faul Bannen				1	License	0335	n.		02	te signe	d (Month, I	Day, Year)	
ι			30. Name and address of person who o	completed cause of	death (Item	23a) (Type, F	Print) Pa	aul	A. I	3ann	en, M	.D.				
2	Sta Registr	te ar	31. Date filed (Month, Day, Year) FEB 2 3 2	32. Regist	rar's Signat	ture A	Solne	20 1/2	MO	20	610					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Chong Twanmo February 19, 2004 7:37p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
July 28,1919 Birthplace (State or Foreign Country) **Funeral** 1∰M 2□F 84 Director 577 48 3119 China Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show The Medical Exactiner must be notified at 1 ☐ Yes 2½ No Maryland Prince Georges Adelphi Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ тетв 23а 1811 Metzerott Road, #201 20783 IISA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify. 3 XWidowed 4 ☐ Divorced Asian "neturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Voice of America/ News Editor Radio Department of Health and Mental Hyg Importent: If item 27 Is marked other any injury or other traumatic event, I once 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be ပ Unknown Twanmo Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Twanmo/Daughter 5040 Scio Church Road, Ann Arbor, Michigan 48103 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 21, 1 □ Burial 2 ☑ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 2004 Alexandria, Virginia permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** um /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): burial-P.O. Box 68760. physician Physiclan/Medical the as IF FFMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should b 3 Probably 4 ☐Unknown Be Completed lensoi 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ha autopsy performe 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 patient 2 ER/Outpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident investigation М 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BABYND KNDERS ON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 23 2004 FEB Registrar

		For State Registrar	State of Maryla	Ce	rtificat	e of L	Death	2. Date o	Reg. I	200	
Physici /Medio	an cal	Decedent's Name (First, Middle, Last) Dwayne	М.	Thom	as			Month 2		04 Year	3. Time of Death 9:54 P _M
Examin	ier	4a. Facility Name (If not institution, give s Prince George's	Medical		Che	ever					George's
uneral irector		5. Social Security Number 6. Sex 578 – 82 – 1401	7. Age (In) 7. Age (In)	rs. lest birthday, Yrs.	Months		If Under 24 Hours	Min. 8. Date of (Month) 7 – 3	Dey, Yee -75	er) 9. Bir	thplace (Stete or Foreign D.C.
febow	Į.	10a. State 10b. County MD P.G.	1	City, Town or L Lanh							10d. Inside City Limits 1 XYes 2 No
3a or 28a at be not	Il Direc	10e. Street and Number 8411 Hamlin St.	, Apt# 10	3	10f. Zip	Code 2070	6	, . <u>-</u>	10g. (Citizen of What Co	
er, or itams 2 Exactinat mu	by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	n U.S. 13.	Was Deced If Yes, spec	cify Cuba	spanic Origin n, Mexican, F Specify:	? (Specify Yes o Puerto Rican, etc.	No-	14. Rece - Ame Black, Whit Specify: B.	e, etc.
r then "netur It's Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us Brick	rk done d se retired	luring most of	f working		Kind of Business	
rked other	To Be C	17. Father's Name (First, Middle, Last) Walter Smith						Name (First, Mic atsy Th			
repaintent or result and wenter hygiene. Department of term 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, its Madical Examination must be notified at ance. Once.		19a. Informant's Name/Relationship (Ty Patsy Alfred — 20a. Method of Disposition 1 Burial 2 (Cremation 3 F 4 Donation 5 Other (Specify)	Mother		Ham	llin ne of other place	St.,		03,1 20c.	y or Town, State, Lanham, Location - City or iverdal	MD 20706 Town, Stete
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cate has been si page 2 should	Completed							a	Vas an utopsy erformed es 2 X	prior to	utopsy findings available completion of cause of 2 No
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	- C = 0		Othe	er.	Death (Check o	4	- 50.	
After this funeral di	tion; To	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	1 Npatient 28a. Date of Injury (Month, Day Yea			28c. Injun Worl	4 140121	28d. Descr		6 □Other (Spe	cify)
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winin 24 hours after of the Funeral Directompletely filled in by	ledical C		sician: To the best of my iner: On the basis of exar and manner stated.								
To the complet	Ž	29b. Signature and title of certifier	pho				s number 547	-18	29d. I	Date signed (Mont	
		500			1	100	3//	/ 0		11101	

-0	955		State of Manyland / Dena	rtment of L	dealth and M	oopies A	ne Legible.	
			1- State of Maryland / Depa 1- State 2-17-04 Registrer/Amend #1.Per MED PGC cr Cent	tificate of	Death	eniai riygii	2003	a gap of mile
2,4	100		1. Decedent's Name (First, Middle, Last) Joycelynn A. Tu	inicate of		2. Date of Death	g. No.	3. Time of Death
	Physic		MY Sa	ruer	0.	Month	Day Year	and the second second
(D)	/Medi Examir		4e. Fecility Name (If not institution, give street and number)	4h City Town o	or Location of Death	FEDRUAL	RY 2, 2004	
1	Lxamii	iei	MALCOLM GROW MEDICAL CENTER			DACE		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	AIR FORCE	8. Date of Birth	PRINCE G	
ξ	Director		577-94-9214 1□ M 2€XF 37 Yrs.	Months Days	Hours Min.	(Month, Day,) July 8,	rear) Co	hplece (State or Foreign buntry) nington DC
	P.		Usual Residence of Decedent			July 0,	LJOO WASI	TINGLOW DC
	show	_	10a. State 10b. County 10c. City, Town or Loc	ation				10d. Inside City Limits
	Ba-1.	cto	Maryland Prince George Forrestvil	.le				1 Yes 2 No
	ath with the Marylan 123s or 28s-f show	Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of What Co	untry?
	ath w	-B	2727 Lorring Drive	207	47	Uı	nited Stat	es
	be filed within 72 hours after death with the Maryland ital Hygiene. of other than "natural", or itema 23a or 28a-1 show event, it a Madical Exercitival is ust be notified.	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	as Decedent of H Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	rican Indian,
36	s afte	by F	XIX Never Married 2 Married 1 Yes 2 X No	☐Yes 2X No			Specify: B1	
00	hour tural							
5	in 72	Completed	(Specify only highest grade completed) (Give ki	ent's Usual Occup ind of work done of O NOT use retired	ation during most of working d)	7	ib. Kind of Business/	Industry
72	iene. Than "	E O	Elementary/Secondary (0-12) Twelth College (1-4or 5+) Domest		-,	1	Private	
D	I Hygie other	0	17. Father's Name (First, Middle, Last)		18. Mother's Name			
Maryland 21215-0036	should be nd Mental marked o	To B	Gerald Turner		Juanita Y		,	
ary	shoul nd Me r mark umati	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street	and Number or Rural	Route Number, (City or Town, State, Z	(in Code)
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alt:	permit. Pag Department Important: I any injury o				ss of Facility Robe	rt G. Ma	son Funer	al Home
Ö	Depa Impo eny i		Williami K. Kungar 160	61 Good 1	Hope Rd SE	, Washir	igton DC 2	0020
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-1862		ner	Sequentially list conditions in any, leading to immediate cause. Enter Underlying	7,000				
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events					
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Вох	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	ctopic pregnancy			23d. Date of deliv	•
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o	Physician: The this certificate had director, page	L ₀	1 Xes 2 No Hospital: 1 Inpatient 2X ER/Outpatient		4 1 Nursing Home		e 6 □Other (Speci	fy)
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Si	death ctor: / the	cal	2 Accident investigation 3 Suicide 6 Could not be 380 Block of fairn. At home form about		res 2 □No			
Division of Vital	l or At after o Direct	Certification:	4 Homicide determined determined determined building, etc. (Specify)	it, ractory, office	281	City or Town, S	t and Number or Rur tate)	al Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the tr	Medical	29a. Certifier (Check only onle) 1□ Certifying Physician: To the best of my knowledge, death or control of the basis of examination and/or investant and manner stated.	stigation, in my op	e, uate and place, and inion, death occurred	at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	To th Mithin To th	Me	29b. Signature and title of certifier	29c. License	number	29d.	Date signed (Month,	Day, Year)
١,			Joshan Geerber Mr	α	CME			, 2004
	3)	1	30. Name and address of person who completed cause of delab (Item 23a) (Type, Pri	int)				
ノ l		+	Tasha Z Greenberg M.D. 111 Pe	enn Stre	et, Baltim	oro Me-	**1 and 010	0.1
AL.	Stat	е	32. Registrar's Signature		· # # TT[[ore, Mai	ATQUA 515	U1
	Registra		FEB 18 2004 Elevent & Speak	,				
DHA	MH 17 Rev 1/20	01						

		1 - For State Registrer	State of Maryla	and / Dep		lealth and M	-	ne	L 0700
Physic		1. Decedent's Name (First, Middle, Last Gloria)		Taylor		2. Date of Death Month Feb. 10,	Day Year 2004	3. Time of Beath 10:30 A. M
/Medi Examir		4a. Fecility Name (If not institution, give 9111 Tallfield Cou. 5. Social Security Number 6. Se	ırt	rs. last birthday)	7	r Location of Death	8 Date of Birth	4c. County of Dee	th eorges
Funeral Director		033-20-1947 10 Usuel Residence of Decedent	^{□ M 2}	Yrs.	Months Days	Hours Min.	Dec. 23,	1928 Bos	
he Marylar 8a-f ehow	Director	Maryland Prince Ge		City, Town or Lo	10f. Zip Code		10-	Citizen of What Co	10d. Inside City Limit
be tiled within 72 hours atter death with the Maryland tal Hygiene. dother than "natural", or Itame 23a or 28a-f ehow event, tra Medical Exactinar must be rectified at	by Funeral Dir	9111 Tallfield Cou	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		20706	lispanic Origin? (Span, Mexican, Puerto	Ur		tes Americ encan Indian, e, etc.
in 72 hou n "natural Ne die al E	Completed t	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work d)	ing 16b	. Kind of Business	/Industry
be tiled ital Hygi od other	Be	12 17. Father's Name (First, Middle, Last) Oscar Keene	College (1-4or 5+)	Legal	Secretai		e (First, Middle, Maid	aw Firm den Sumame)	
permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked cent injury or other traumatic event injury or other traumatic events.	To	19a. Informant's Name/Relationship (7) Cynthia Taylor/Dau 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify, 21. Signáture of Fune)al Service Licens	ghter 200 Removal from State Q	9111 p. Place of Dispo cemetery, cre quantico	Tallfield position (Name of matory or other place National	and Number or Rundle Court La	anham, Mar Date 2004 Tr	yland 20 Location - City or	706 Town, State
Physician /Medical Examiner per partial pe	cal Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	a. Coronary Due to (or as a cons	Artery sequence of): Athero			or respiratory arrest,		Approximate Interval Between Onset and Death
ne death certitica the attending ph thed for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	23c. If yes, outcome of preduction 1 Live birth 2 Fig. 4 Pregnant at time of 9 Unknown	etal death 3[□Ectopic pregnancy □ Other (specify)	,		23d. Date of de Month	ivery Day Year
Se G	by	Part II. Other significant conditions co	ntributing to death but not i	resulting in the u	inderlying cause giv	en in Part I.	23e. Did tobacc		o the cause of death? robably 4 Unknow
The law ete has b page 2 si	Completed						24a. Was an autopsy performed 1 Yes 2 🔀	? prior to death?	utopsy findings availal completion of cause of
yercian: is certific director,	To Be (1 105 223110	Hospital: 1 ☐ Inpatient 2			er: 4 Nursing Ho	n (Check only one) me 5 Residence		cify)
or Attending after death. Director: After in by the fune	Certification:	27. Manner of Death 1 Shatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year, 28e. Place of Injury - A building, etc. (Spe	t home, farm, st	Wor M 1□	Yes 2 □ No	28d. Describe how in 28f. Location (Street City or Town, St	t and Number or Ri	ural Route Number,
le Hospital 124 hours a le Funerel I Hetely filled	edical C		vsician: To the best of my liner: On the basis of exam and manner stated.						
To the within 2 To the complete	Me	29b. Signature and title of certifier	MM		29c. Licens D00	e number 19220		Date signed (Mont 16/2004	h, Day, Year)
(5)		30. Name and address of person who a	65 Grove st	reet	,	y, Ma. 02	181		
St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Sig	gnature	- e				

		For State	State of Maryla	ind / Depa		Health and	Mental Hygi	ene 200	1. 0700
Physicia		1. Decedent's Name (First, Middle, Last) Willie Atkinso		08	i illicate Ul	Deall	2. Date of Death Month February	Day Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	street and number)			or Location of De		4c. County of Dea	1943 F
Funeral Director	à	Prince George's C 5. Social Security Number 6. Sex 578-44-7907	7. Age (In yr	spital rs. last birthday) 79 Yrs.			n. (Month, Day,	Year) 9. Bi	George's thplace (State or Foreigountry) th Carolina
be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23e or 28e-f show event. Ite Medical Examinet must be notified at	by Funeral Director	1 Never Married 2 Married	George's Tive 12. Was Decedent Ever in Armed Forces? 1 Yes 2 X No If Yes, Give		Capito1			14. Race - Am Black, Wh	d States
hin 72 hour. h in "natural" Medical Ex	Completed b	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: cation completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of w	orking 1	6b. Kind of Business	
b d all	Be	12th 17. Father's Name (First, Middle, Last) Henderson Edw			Recept	18. Mother's N	ame (First, Middle, M. Elena C	aiden Sumame)	rnment
s 1 and 2 should be f Health and Mental Item 27 is merked other traumetic ev	ဥ	19a. Informant's Name/Relationship (Ty) Cornell Thomas —	oe, Print)				Elena C Bural Route Number, Capitol He	City or Town, State,	Zip Code) 20743
it. Page rtment o rtant: If njury or		20a. Method of Disposition 1 Disposition 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State	cemetery, crei armony N	esition (Name of matory or other plantatory or other plantatory) Memorial P. Name and Address	Park 2/2		Landove	er, MD
Depa Depa Impo any i		23a. Part I Enter the disease, or complishook) or heart failure. List only or	levour TI		4001 E	Benning D	Rd., N.E.	Wash., DC	20019
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w requires that the de been signed by the should be detached	ed by Ph	Part II. Other significant conditions con Find Huge Ven O	tributing to death but not re	esulting in the u	nderlying cause giv	ven in Part I.			the cause of death?
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ysician s certifi director	To Be	25. Was case referred to medical examiner?	ospital: Inpatient 2	☐ ER/Outpatier	nt 3 DOA Ott	C-12	eath (Check only one) Home 5 Residen		cital
tending Phy Jeath. tor: After thi the funeral of		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. injui Woo	rv at	28d. Describe how		city)
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To the Hospital within 24 hours a To the Funaral Completely filled	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examir one)	sician: To the best of my kner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the till vestigation, in my o	me, date and place opinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	L		29c. Licens			Date signed (Mont	h, Day, Year)
(5)		30. Name and address of person who co	mpleted cause of death (Its		Print) Mure, G	breverly	MD 2078	<i>j</i> -	
Sta Registra	_	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	K)				

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			For	State of Maryla		•			Mental Hy	giene	2001	07	000
			State Registrar			Certifica	te of D	eath			2004		888
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<i>)</i> :	Examin	er	4a. Fecility Name (If not institution, give					ocation of Death	h	4c.	County of Dead	h	
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	pu .	}	Usual Residence of Decedent 10a. State 10b. County	10c.	City Town	or Location						10d. Inside C	City Limits
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	be filed within 72 hours after death with the Maryland at thygiene. All the Warland of other than "natural", or items 23a or 28a-f show do there than "natural", or items 23a or 28a-f show event, it a Madical Exacides must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever i	nlis	13 Was Dec			nacify Yes or No		S . A . 14. Race - Ame	ncan Indian	
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ŏ	within 72 hours after ene. than "naturel", or ite the Medical Exactine	pe	15. Decedent's Ed	ucation	16a.	Decedent's Us	ual Occupat	ion		16b. Ki	nd of Business/	Industry	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should by Opparment of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Relationship (ype, Print)		_			ıral Route Numbe				
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	/Medical		resulting in death)	Due to (or as a con									
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<u>></u>	l or At after o Direc	ıı	4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	ecify)	rm, street, facto	ory, office		28f. Location (S City or Tox			irai Houte Nui	noer,
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	B		() ()	nomplated squae of days	(Item 22a) /				MEHTI		and a	-1 , 0	004.
J.	(5)		30. Name and address of person who	0	item 23a)	_	-		NO MO		1100		
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			For State	State of Maryland / Dep			ZUIII	07889
			1. Decedent's Name (First, Middle, Last	2826 PER PHY G829 3/19/	Minimate of Death	2. Date of Death	. No	3. Time of Death
	Physicia /Medic	al -	MARY ELIZABETH TE	MPLE		FEBRUARY		5:00 PM M
1	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	
			EDEN PINES NURSIN 5. Social Security Number 6. Sec		HAGERSTOWN If Under 1 Year If Under 24 Hrs.	8. Date of Birth	WASHINGTO 9. Birth	
	Funeral Director			M 2 X F 94 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, You 6/15/190)	9 VIR	place (State or Foreign intry) RGINIA
	land ow		10a. State 10b. County	10c. City, Town or I	_ocation			10d. Inside City Limits
	the Marylan 28a-f show natified at	ţ	WV PENDLETO	N BRANDYWIN	NE			1∐Yes 2XX No
	th the	irec	10e. Street and Number		10f, Zip Code	10g	. Citizen of What Cou	intry?
	23a (23a (15)	ä	U.S. ROUTE 33 WES		26802		.S.A.	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or liems 23a or 28a-f show other tream after a marked other than "natural", or liems 24a or 28a-f show other treamatic svent, it is Marileal Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Pes XXNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: WHI	, etc.
215-0036	s hou	ed	15, Decedent's Edu	ugation 16a Dec	edent's Usual Occupation	16	b. Kind of Business/Ir	ndustry
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멀	2 should be filed withln and Mental Hygiene. is marked other than eumatic svent, Ire III.	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Ma.	iden Sumame)	
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Maryland	and 2 sho saith and n 27 is m		19a. Informant's Name/Relationship (T) HARRY LEE TEMPLE	(lling Address (Street and Number or Rur			p Code)
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State 20b. Place of Dispersion Communication	ematory or other place)		c. Location - City or T	
Ħ	⊢ m ⊐	1	21. Signature of Funeral Service Licens	ORGINITA	ON SERVICE 2-27 22. Name and Address of Facility	-04	IAKKISONDU	RG, VA
Ba	permit, Departr Imports any inj once.	- 1	() 1/2 / 2/2	Breser I	BASAGIC FUNERAL HOP	E FRANKLI	IN. WV 268	07
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o uo	ding Ph h. After th funeral		27. Manner of Death 1 ∯Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how	injury occurred	LIVING
Division	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	dical C	29a. Certifier (Check only one) Certifying Phy	rsician: To the best of my knowledge, dea finer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier		29c. License number		. Date signed (Month,	
				ned	052323	0	2/27/04	
	ed			ompleted cause of death (Item 23a) (Type	e, Print)			
_			Dr. Waseem -11	26 Opel Ct Ho	agerstown, MD &	21740		
	Sta Registi		31. Date filed (<i>Month, Day, Year</i>) MAR 1 1 2004	2.6 Opel CtHo	roll.			

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not institution, give street and number)	4b. City, Town, or Location of Death	,	4c. County of Death		

1. Decedent's Name **Physician** 6 ATY /Medical 4a. Facility Name (If Examiner SINAI Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) · tay ROTHMON 4021 Ut If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1⊠M 2□F 57 Yrs Washington, DC Director 579-56-8902 March 4,1946 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages t and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 72 is marked other than 'natural', or items 23s or 28e-f show any injury or other traumatic event, in Marcie Examination and the Defiliation. MD Baltimore 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4511 Maine Avenue 21207 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ď No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Warehouseman Private Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jonas Underwood Catherine Lancaster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy M. Perry/Daughter 1702 Crossbay Court, Severn, MD 21144 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Tremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) Riverdale Crematory 02/19/2004 Riverdale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Avenue Suitland, MD 20746 in 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myo capilin /Medical Due to (or as a consequence of): Examiner ATDIO VASCULAN ATRIOSCUEDON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine HYPECHONESPENDINEMIA that initiated events resulting in death) Last sicien ar Due to (or as a consequence of): Box 68760. Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Year ૃં Month Dav 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à LATERAL SCHLEHOKIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?/ Yes 2 No page 1 ☐ Yes

or Attending Physician: Be this Certification: After death. after death Director: the in by

P.O. Division of Vital Records, To the Hospital or within 24 hours aft To the Funerel Di completely filled in

Medicai

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

>mD ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add

2 0 2004

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical

29b. Signature and title of certifie

exammer? 1 ☑ Yes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only

4 - Homicide

D. WINGTON

28a. Date of Injury (Month, Day Year)

Hospital:

3100 TOWANDA

3 DOA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

30408

ME

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2. Registrar's Signature

1 Inpatient 2 FVOutpatient

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

J		State of Maryland / E 1 - State Registrar Unpend Item#23a,27,28a-f,Per ME, (Pepartment of Health and Mental F	Hygiene Reg. No. 2004 0789
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) David Wayne Vetter 4a. Facility Name (If not institution, give street and number) 255 Lore Road, Boat Slip#3	2. Date of Month Februa 4b. City, Town, or Location of Death	Death Day Year 3. Time of Death 21, 2004 02:50 P.M. 4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt. 1 M 2 F 55	Solomon's Island hday) If Under 1 Year If Under 24 Hrs. 8. Date of (Month, Yrs. Months Days Hours Min. Feb 1	Birth Day, Year) 7 1949 Calvert 9. Birthplace (State or Foreign Country) 7 1949 Washington D
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28a-1 show eny injury or other traumatic event. If a Medical Exercite et must be registed.	To Be Completed by Funeral Director	Elementary/Secondary (0·12) College (1·4or 5+) 10th 17. Father's Name (First, Middle, Last)	20688 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 Ruby Gautie Ruby Gautie Ruby Gautie Mailing Address (Street and Number or Rural Route Num 55 Pan Drive Walderf, Disposition (Name of pate) (crematory or other place) (crematory or othe	10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? United States No- 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry COnstruction dle, Maiden Sumame) representation City or Town, State Coloration - City or To
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on of Vital ding Physician: After this certifications of the second of	Certification; To Be C	27. Manner of Death 1 Natural 5 Pending 28a Date of Injury 28b Till 28b T	30 p M 1 ☐ Yes 2 X No Unknown 1, street, factory, office 28f. Location City or T	(one)
Divisit To the Hospital or Attent within 24 hours after death To the Funeral Director: completely tilled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, and manner stated. 29b. Signature and title of certifier	death possured at the time, date and class, and due to the	
Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (The state of the complete of the complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of death (Item 23a) (The complete of the cause of th	ype. Print 111 Penn Street, Balt	

			For State Registrar	State of	Marylan		irtment of l	Health and N Death		0	004	การจา
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	Examir		4a. Fecility Name (If not institution, s Suburban Hospi	tal			Bethe				y ol Death gomer	
	Funeral Director		5. Social Security Number 578-24-6205 Usual Residence of Decedent	. Sex 7 1 ☐ M 2 🖾 F	. Age (In yrs. Id 88	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bird (Month, Da May 11	y, Year) , 1915	9. Birthi Cou Penn	place (State or Foreign ntry) ISY 1vania
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evention in trained by notified at once.	ctor	10a. State 10b. County Md. Montgo	mery	10c. City	, Town or Lo	cation nsington					10d. Inside City Limits M☐ Yes 2 ☐ No
	ath with the 23a or 28	rai Director	10e. Street and Number 4225 Dresden S	treet			10f. Zip Code 20	895		10g. Citizen of	What Cou	ntry?
036	urs after dea al', or Items	by Funerai	11. Marital Status 1 □ Never Married 2 ② Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Force 1	es? ≹ No	1	Vas Decedent of I Yes, specify Cub ☐ Yes 2 XNo	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rai Bla Specif	ce - Americk, White,	
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and 21	d be filed wantal Hygier to event, to	Be	17. Father's Name (First, Middle, La James Vincent			Но	memaker/	Writer 18. Mother's Name Lucy Max		Own Maiden Suman		
Marvland	nd 2 should alth and Me 27 Is mark	To	19a. Informant's Name/Relationship Joseph P. Vaghi,	(Type, Print)	and			and Number or Run	al Route Numbe			Code)
Baltimore.	Pages 1 a nent of Hes ant: If item ury or othe	1 1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		219	ace of Dispos metery, crem	ition (Name of atory or other pla	сө)	Date 14,04	20c. Location -	- City or To	
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	Examiner	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Obsease or injury	b. 1+	as a consequence as a consequence	WSF	3/				1	
2 pm 8760,	rate be executed shysicien and the burial-transit	dicai Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a conseque	ence of):						
6:12 Box 68	ing p	an/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnan		Ectopic pregnancy	,		23d. Dat	te of delive	ry
	at the by th tache	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown Part II. Other significant conditions	4□Pregnan 9□Unknow	t at time of dea	ath 5	Other (specify)					Day Year
2/10/04	v requires been sign should be		Takin. Ottor significant conditions	contributing to deat	TI Dat not resur	ung at the un	seriying cause giv	en in Parti.	1 🗆 Y	es 2 No	3 Proba	ably 4 Mknown
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	Phys	ToB	examiner? 1 Yes 2 No 27. Manner Death 1 Natural 5 Pending	Hospital: 1 np 28a. Date of I (Month,		R/Outpatient 28b. Time of Injury	28c. Injur Wor	4 🗆 Nursing Hor	St. William Co	ence 6 Oth)
n25 Division	el or Attending s after death. Il Diractor: After id in by the fune	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At hometc. (Specify)	ne, larm, stre	M 1 []	Yes 2 □ No	281. Location (SI City or Town	reet and Number, State)	er or Rural	Route Number,
B	To the Hospitel or Attendwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edicai	one)	Physician: To the be aminer: On the basis and manner	s or examination	ledge, death on and/or inve	stigation, in my o	pinion, death occurre	and due to the cared at the time, d	ause s and ma ate and place, a	nner as sta and due to	ited the cause(s)
	Neith To Con Con Con Con Con Con Con Con Con Co	Σ	29b. Signature and title of certifier	000	w		29c. Licens			9d. Date signed FCBU1		
	Sta	e	30. Name and address of person who all the second of the s	oterw	ol death (Item 2	23a) (Type, P	Sparks	N INSA	FMZ,	50m	, NA	10 2004 MO
dies	Registra	-	FEB 1 7 2		مصماعه	19	Sparks	/	-			

To the Hos within 24 h To the Fur		Medical	(Check only and medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier APPARA, Medical Doctor RES - 000 February;									to the cau	ar)		
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filed in by the funeral		al Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Inj building, et sician: To the best	of my kno	(y) owledge, death	n occurre	City or Town, Sta							
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t the deby the		Physician/medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)									23d. Date of delivery Month Day Year acco use contribute to the cause of death?			
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permit. Pages 1 and 2 Department of Health a Important: If item 27 is	Ь		20a. Method of Disposition 1 ☐ Burial 2 ∑ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Place of Disponentery, crer	natory o	other place)		/2004		exandri			
and 2 sh salth and n 27 is m			19a. Informant's Name/Relationship (Ty. Tuuli Vocke / Wif			4000	Mas	sachu	setts Av	e., NW	#805	, Wash	ingtor		
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ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If filem 27 18 marked of their than "natural", or items 23a or 28a-1 ehow or their fearmafte event the Medical Examine Trust be notified as		2	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	2 (XNo 9 1			Mas Decedent of Hispanic Origin? (Specify Yes f Yes, specify Cuban, Mexican, Puerto Rican, et l □ Yes 2🌠 No Specify:				14. Race - American In Black, White, etc. Specify: White			
th with t		Funeral Director	10e. Street and Number 4000 Massachusetts	5	101. 2	20016	Germany								
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D	1		Usual Residence of Decedent										de City Limits		
Fune			5. Social Security Number 6. Sec. 1 31-80-4940		je (<i>In yrs.</i> 34	last birthday) Yrs.	Month Month		Hours Min.	8. Date of B	(15)	969 9. B	irthplaca (St. Country) German	ate or Foreign	
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/Me	sicia: edica	ıl -	Matthia S 4a. Facility Name (If not institution, give:	street and number)	mber) 4b. City, Town, or Location of De					Februa		County of De		28 AM	
			1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Month Day Year 3												

State of Maryland / Department of Health and Mental Hygiene 004 07896 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Feb. 24, 2004 **Physician** Valencia 6:30р м Irene Reyes Sofia /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days **Funeral** Hours 1 □ M 2 XF 80 Peru none 9/18/1923 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State worle 10b. County f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28s-1 ehow other traumatic event, the Medical Examinar must be notified at Silver Spring 1 ☐ Yes 2 No Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20902 11939 Andrew Street Peru Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be tiled within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Ita any injury or other traumatic event, the Medical Exatators 1 Never Married 2 Married White 1⊠Yes 2□No Specify: Peru Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emerico Eleodoro Reyes Maria Valencia Vivar 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carmen Sandoval Reyes/Daughter 11939 Andrew St. Silver Spring, Md20902 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State 20a. Method of Disposition campo Fe Cemeterio3/04/04 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lima, Peru 4 Donation 5 Other (Spegify) 21. Signature of Funeral Service Jog PHILIP ADOSRINALDI FUNERAL SERVICE, P.A. Mily . 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death a ATHEROSCIONATIO CAPROPOLASCICARE DISTAS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No this certificate 1 Yes 2 📮 1 Tes or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 FR/Outpatient 3 DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check drift) one) To the ! 29c. License numbe 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier FEBRUARY CLG, 2004 U15236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINO, BOOK ULLO, 40 20352 AGU I. MARGOUS IND MUX ROCKIUS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Oaks 27 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 18, 2004 February **Physician** Lorraine Ann Valkos 8:20 A. M /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Knollwood Manor Nursing Home Millersville Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 21, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2⋤F Months 579-48-2518 Wash. D.C. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If Item 27 is marked other then 'naturel', or Itame 23a or 28a-1 ehow ury or other traumatic event, Ita Marileal Examinat Le multime an ury or other traumatic event, Ita Marileal Examination. 1 Yes 2 No Completed by Funeral Director Anne Arundel Millersville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 899 Cecil Ave. 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler Electronics 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph A. Florimbio Jessie A. Lippencott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 Shady Oak Ct. Robin Friese / daughter Chesapeake Beach, MD, 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Department of the Important: If Ite eny injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 2-21-2004 Brentwood, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Lice see 6512 NW Crain Hwy. Bowie, MD. ar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician Due to (or as a consequence of): & clary resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physiclan/Medicai Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Year Day 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cirrhosis 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) bything, WD DO015000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po-Hsiu Hung. M.D.
31. Date tiled (Month, Day, Year) 916 Crain Hwy, SW. & Glen Burnie, Md. 2106/ 32. Registrar's Signature State Registrar 1 9 2004

			For State Registrar	State of M	arylan	-	artmen <i>tificat</i>			and M	ental Hy	giene	2004	078	396
	4	1	Decedent's Name (First, Middle, Last)									ath Day	Year	3. Time of D	eath
	Physicia /Medic		Angelina Anna Vollmer									ry 15	, 2004	8:00	а ^м
	Examin	er	4a. Facility Name (If not institution, give						Location of	of Death			4c. County of Death Prince George's		
			Doctor's Communit 5. Social Security Number 6. Sec			last birthday)	L &	nhan	If Under	24 Hrs.	8. Date of Bir	th			Foreian
Philapy	Funeral Director			M 2XF	88	Yrs.	Months		Hours	Min.	June 8	1915	Wash	olace (State or I ntry) ington,	DC
	ligo.		Usual Residence of Decedent		1										
7	show	Ļ											10d. Inside City 1 X Yes 2		
3	the Market 1	ectc	Maryland Prince George's Riverdale 106. Street and Number 106. Zip Code									10a Citiza	n of What Cou		
2	with	급	6314 Roanoke Avenue 20737									U.S		,	
2	death w	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? It Yes, specify Cuban, Mexican, Put							gin? (Spe	cify Yes or No		14. Race - American Indian, Black, White, etc.		
8 8	urs after death with the Maryla al', or items 23a or 28e-f shor Examilier Indel by rediffed al	Fur	1 Never Married 2 Married	1 Yes 2 X	No	1	res,spec I∐Yes	**	Specify:		Hican, etc.)				
5-0036	72 hours "netural", olical Exe	d by	3 X Widowed 4 □ Divorced	Year or Dates:									, W1	ite	
2 -51	within ene. than	olete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)							16b. Kind of Business/Industry					
22		Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Homem						Own	Own Home		
P		3e C	17. Father's Name (First, Middle, Last)								(First, Middle		ітате)		
Na S		To Be	Antonio Santilli								Germa				
Mar	and and is in		19a. Informant's Name/Relationship (Ty	•			_						own, State, Zip		
	Health tem 27 other tra		William F. Vollme 20a. Method of Disposition	r - 50n	20b. F	2 / U O Place of Dispo semetery, cren					ate W		ds, MD tion - City or To		_
nor	ages ant of nt: If it		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		emetery, cren Mary †				2/10.	2004	Wash	ington,	ъс	
Baltimore,	permit, Pages 1 Department of F Importent: If ite any injury or ot		21. Signature of Funeral Service Licens	эе	DC.	-			-				1 Home,		
ä	Depa Impo any it		Plandette Yash Jaruma 4739 Baltimore Ave., Hyattsville, MD 20781												
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between												en
	Physician		Immediate Cause (Final disease or condition resulting in death)	Lue	umi	ONLE								Onset and De	ain
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):	w= /-	former.	O. L.	acu b	S. Car	00000			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):	UG	W	TUIL	now	ry vis	CUSE	_		
	d d arisit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Carred	TIU	e. He	ut1	211	1AC						
ó	be execuled sicien and burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):		ili Savily							
8760,	ate be shysici the bu	lical	•	J											
Вох 68	leath certifical attending phy I for use as th	by Physician/Med	IF FEMALE:	3c If yes outcome	of nreans	ancy						20	. Data at dalia		
Во	atten for u	clan	23b. Was decedent pregnant in the past 2 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown									23	23d. Date of delivery Month Day Year		
P.O.	that the de ed by the detached	hysl													
	es thai igned t	by P	0 0	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								obacco use	acco use contribute to the cause of death?		
ord	w require been sign	ted	CORONARY HETERY DISCORE								1 Yes 2 No 3 Probably 4 □L				
Š	elawr hasbe je 2 sh	Completed	`								24a. Was an autopsy performed? 24b. Were autopsy find prior to completion death?				allable ise of
<u>=</u>	hysicien: The la nis certificate ha I director, page 2										1 ☐ Yes	2 No	death? 1 ☐ Yes	2 No	
<u> </u>	sicien certifi rector	Be c	25. Was case referred to medical examiner:	lospital:		5D/0		Othe	P		(Check only o		201 10		
ō	ding Phys h. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred 28d. Describ									y)			
ioi	Attending I death. ictor: After y the funer	atlo													
Division of Vital Records,	of or Attence after death Director:	tifle	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							1	281. Location (Street and Number or Rural Route Number, City or Town, State)				
	spitel or ours afte neral Dir filled in														
	To the Hospitel or Attending Physicien: The law requires that the death certificate be execu within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-tra	edical	29a. Certifier Tell Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	To the Hosi within 24 ho To the Fund completely f	Med	29b. Signature and title of certifier 29c. License number								29d. Date signed (M			Day, Year)	
	F % F o		1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/							16 Bowie, mo 207/6					
0.0	(7)		30. Name and address of person who co	ompleted cause of	death (Iten	n 23a) (Type,	Print)	-11	ח	0			, - ,		
CIL			allen Du Baye	e mo	4000	MITCH	relluj	16 1	lad	62	16 B	owce	, mo	207/6	
	Sta Registr		31. Date filed (Month, Day, Year) FFB 1 8 2004		rar's Signa	A A DO	de								

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State of Maryland / Department of Health and Mer	ntal Hygiene 2004	07897	-
Certificate of Death	Reg No.	. 1 . 5	•

2. Date of Death

Month

Day

Year

3. Time of Death

Physic /Medi Exam

Funera Director For State Registrar

1. Decedent's Name (First, Middle, Last)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examinating Incititing at once.

Physician /Medica Examine

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ical	Harold L. Venable		# 63 T	- I of Darah	FEBRUAF	RY 10,200	
ner	4a. Facility Name (If not institution, give street and number,			Location of Death		4c. County of D	
	PRINCE GEORGE'S HOSPITAL CE	NTER ge (In yrs. last birthday)	CHEVERLY If Under 1 Year	If Under 24 Hrs.	8 Date of Birth		GEORGE S
	1 XM 2 F	Vre	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 6,	Year)	Birthplace (State or Foreign Country) Wash., DC
	578-92-6568 Usual Residence of Decedent	31			reb. 0,	19/3	wash. DC
	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
ō	District of Columbia		Was	hington			1 X Yes 2 ☐ No
rec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
0	1114 F St., N.E. #306			20002		Unite	d States
era	11 Marital Status 12, Was Decedent	Ever in U.S. 13. V	Was Decedent of H	ispanic Origin? (Sp nn, Mexican, Puerto	ecify Yes or No-	14. Race - A	merican Indian.
F	Armed Forces 1 Never Married 2 Married 1 Yes, Give	No			Hican, etc.)		African
by	3 Widowed 4 Divorced Year or Dates:	33	1□Yes 2∏XNo	Specify:		Specify:	American
ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation during most of work	ring 1	6b. Kind of Busine	ss/Industry
pje	Elementary/Secondary (0-12) College (3-4or	lite 1	DO NOT use retired Realt	1)		Colf_E	mployed
Completed by Funeral Director			Realt				mproyeu
Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, N		
ပု	Harold L. Venable, Sr.					Anderso	
	19a. Informant's Name/Relationship (Type, Print)		,	and Number or Rur			
	LaShawn Murray - Sister			St., N.V			
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	isition (Name of natory or other plac	(a)	Date 2	20c. Location - City	or Iown, State
	* 4 □ Donation 5 □ Other (Specify)	Harmony M			/2004	Landov	ver, MD
	21. Signature of Funeral Service Upensee	22	2. Name and Addre	, ,		Funeral H	
	John I. Lewart I			enning Ro			
	23a. Part Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not enti line.	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	tiple qu	unsho	t wo	uds		Onset and Death
	resulting in death) Due to (or a	s a consequence of):					
	Sequentially list conditions, b.						
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of).					
Examiner	that initiated events c.	s a consequence of):					
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nysician/Medicai	d						
/Me	IF FEMALE: 23c. If yes, outcom	e of pregnancy				23d. Date of	delivery
cian	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)	,		Month	Day Year
ıysi	1 Yes 2 No 9 Unknown						
죠	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause giv	en in Part I.	23a. Did tob	acco use contribute	to the cause of death?
d by					1 ☐ Ye	s 2.0XNo 3□	Probably 4 Unknown
lete					24a. Was an	24b. Were	autopsy findings available
Completed					autopsy	ned? death	
Ö	25. Was case referred to medical			26 Place of Deat	1 Yes 2 th (Check only one	□ No 1,28.Y	′es 2 □ No
To Be	examiner? 1XXYes 2 No Hospital: 1 Inpat	ienI 2 X ER/Outpatien	nt 3 DOA Oth	er		nce 6 Other (S	(pecify)
H	27. Manner of Death 28a. Date of Inj	ury 28b. Time of	f 28c. Injur	y at	28d. Describe ho		poony
tio	1 Natural 5 Pending (Month, D		Wor 1□	Yes 2 No	Porecuse	I shot	
ifica	3 Suicide 6 Could not be 28e. Place of Ir	njury - At home, farm, str			28f. Location (Str	eet and Number or	Rural Route Number, BIL Bartier St.
Certification:	Homicide building, e	street			S.E. WI	ASH. D.	C, Burlier St.
ai	29a. Certifier 1 Certifying Physician: To the bes	t of my knowledge, death	h occurred at the tir	ne, date and place,	and due to the ca	use(s) and manner	as stated.
Medical	(Check only one) Medical Examiner: On the basis and manner s	or examination and/or in- tated.	vestigation, in my 0	pinion, death occur	reu at the time, da	tte and place, and c	due to the cause(s)
Σ	29b. Signature and ville of certifier	1	29c. Licens		29	d. Date signed (Mo	onth, Day, Year)
	MI (1AN//V			CME	FI	EBRUARY 1	1,2004
	30. Name and address of person who completed cause of	death (Item 23a) (Type,					
	S. R. HOGAN		111 Penr	Street,	Baltimo	re, Maryl	and 21201

State

Registrar

31. Date filed (Month, Day, Year)

1 8 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 22,2004 2040^M Louis Walls, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Memorial Hospital Easton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Director 220-28-1972 71 March 21, 1932 Maryland filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23s or 28s-1 show svent, the Medical Examinar must be notified at 1 Pres 2 □ No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States
14. Race - American Indian,
Black, White, etc. 702 Camp Road 21629 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status No Yes 2 No 1953-If Yes, Give Year or Dates: 1955 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify by 3 Widowed 4 Divorced 1955 Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens important: If item 27 is marked other the enty rijury or other traumatic svent, the 900cs. 9 Owner/Operator Auto Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James Medford Walls <u>Sarah Hazel Parks</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matilda S. Walls 702 Camp Road, Denton, Maryland 21629
e of Disposition (Name of Date 20c. Location - C Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Md Fastern Shore Veterans 2/26/2004 1 \Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Beulah, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moore Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate (00% Immediate Cause (Final disease or condition resulting in death) **Physician** Ventricular /Medical Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): -Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier D0047534 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 920 Market Street, Denton, Maryland Wafik Zaki, M.
31. Date filed (Month, Day, Year) State FEB 2 6 2004 Delle Ser Registrar

DHMH 17 Rev 1/2001

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NHEALTON

		1	For State Registrar	State of Mary		artment of H rtificate of I		Mental Hyg	giene Reg. No. 6	2004	07900
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month		Year	3. Time of Death
	ysicia Iedic	al L	Richard		ttingham			Februar			10:35 P M
Ex	amine	-	4a. Facility Name (If not institution, give			4b. City, Town, or Waldor	r Location of Death -F	ו	1	County of Death	
			2604 Hatteras Circ		yrs. last birthday)	If Under 1 Year		8. Date of Birtl			place (State or Foreign
Fun Dire			371-52-9156	ĎM 2□F 5	4 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day CEMBEL 2	26°, 19	49 Mich	ligan
P.	11-1	-	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation					0d. Inside City Limits
anylar show	7	5			Waldo						1 XYes 2 No
the M	at the	Director	Maryland Charles 10e. Street and Number		Waldo	10f. Zip Code			10g. Citiz	en of What Cour	ntry?
death with the Maryland ms 23a or 28e-f show	941	ੂ	2604 Hatteras Circ	cle		20601			USA	1	
death ms 2	E	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	. 1	4. Race - Americ Black, White,	
CTZ IS-UUSO I within 72 hours after death with the Marylan jiene. rthen "natural", or ttems 23a or 28e-f show	eclina		1X Never Married 2 Married	1 ☐ Yes 2X No ff Yes, Give		1 ☐ Yes 2X No	Specify:	,			lack
OUSD hours at tural, or	al Ex	d by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occur	ation		16b. Kin	d of Business/In	dustry
within 72 ene.	Andic	Completed	(Specify only highest gra	de completed)	life.	dent's Usual Occup kind of work done DO NOT use retired	7)	rking			,
Id 212 filed withir Hygiene. other then	the A	ШО	Elementary/Secondary (0-12)	College (1-4or 5+)	Sale	s Person			Syms		
be filed tal Hygid	vent,	Bec	17. Father's Name (First, Middle, Last)					ne (First, Middle,			
Me sa	atic	ပ		ttingham	Sr.	na Address (Street	Constanc		Thoma		Codol
0 4 2	traum		19a. Informant's Name/Relationship (7		1	Hatteras					
Heal	흎		Constance Druitt/		Ob. Place of Dispo	osition (Name of		Date	20c. Loc	ation - City or To	own, State
Pages	y or o		N☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		cemetery, cres St. Marys	matory or other places. Ch. Cem.	2/26	5/04	or yar	Maryla	ind
Baltimore, permit. Pages 1 au Department of Hea Importent: If item	any injury or o once.		21. Signature of Funeral Service Licen		2	2. Name and Addre		_			7
n kā!	00		Dalosa Oy	0		Adams Fun				co, Maryl	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not en	ter the mode of dyir	ng, such as cardiad	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physic			Immediate Cause (Final disease or condition resulting in death)	a	Hepalel	00	liver	farlen			yours
/Med Exam			resulting in county	Due to (or as a co	ons-fuence of):			/			/
		ē	Sequentially list conditions,	b. Due to (or as a co	onsequence of):						
o uted	ansit	Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
О, в ехес ian an	urial-tr	EX	resulting in death) Last	Due to (or as a co	onsequence of):						
I Records, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and	the burial-transit	dicai		_ d							
× 6 Sertific	Se as	/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy				2	3d. Date of deliv	ery
Box eath cer attendin	detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	y 			Month	Day Year
the d	ached	hysi	9 Unknown	9□ Unknown							
S, Po	be det	by P	Part II. Dther significent conditions of	contributing to death but n	ot resulting in the u	underlying cause giv	en in Part I.		/		he cause of death?
ord: equire	should	ted	HIV					1 🗆 🗎		1	bably 4 □Unknown
Peccelaw repairs the best best best best best best best bes	O.	Completed						24a. Was autop		24b. Were auto prior to co death?	opsy findings available empletion of cause of
Vital Records, stcien: The law requires t	r. pag						0 /0	1 ☐ Yes	2/□ No	1 🗆 Yes	2□ No
Vit.	recto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA	26. Place of De	Home 5 Resid	dence 6	☐Other (Speci	fv)
Vision of Vita Attending Physicien: It death.	eral d	H	27. Manner of Peath	28a. Date of Injury (Month, Day Ye	28b. Time o		10000	28d. Describe I			,,
inding after After	e fun	atio	1 Natural 5 Pending 2 □ Accident investigation	n	sar/ Injuty		Yes 2 □No				
Division of a tor Attending Physical death.	by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	 At home, farm, st Specify) 	treet, factory, office		28f. Location (S City or Tox			al Route Number,
Doitet o	lled ir					th converse at the tr	mo data and place	a and due to the	causo(s)	and manner as	tated
Division Hospitet or Attending 24 hours after death. Funeral Director: After	ately fi	edical	29a. Certifier 1 ☐ Certifying Pl (Check only 2 ☐ Medical Examone)	nysician: To the best of n niner: On the basis of ex and manner stated	amination and/or in	nvestigation, in my	opinion, death occ	urred at the time,	date and	place, and due t	to the cause(s)
Div To the Hospitel or within 24 hours afte To the Funerel Dir	completely filled in by the funeral director, page	Med	29b. Signature and tiple of certifier	1// 00	м	29c. Licen	se number		29d. Date	e signed (Month,	Day, Year)
F 3 F	J		De Carl	to W	130	10	2975		2	~ 23-	.04
10	->		30. Name and addre	include a deat	(Item 23a) (Type	Print) Da	nel Ho	owell	6		
ككلان	Ó		11345 Temb	32. Resistrar's	Signature	Julas	ma	1.206	003	•	
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		•	For State Registrar	State of Ma				nt of H	ealth a	and M	ental Hy	giene Reg. No	200) 4	079	01
			Decedent's Name (First, Middle, L	ast)							2. Date of De Month	ath			3. Time of De	ath
	Physicia /Medic		Wilbur Sangst	on Willey	Jr.						Februa	ry 1	8 200		9:00	a ^M
	Examin		4a. Fecility Name (If not institution, g				,		Location	of Death		1	. County of D			
			406 Shepherd A					ambr:		0411-0			Dorche			
	Funeral		5. Social Security Number 6. 218–20–8872	Sex. 7. Ag 1 ☑ M 2 ☐ F	16 (In yrs. 76	last birthday Yrs.	Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da May 29	th ly, Yeer) , 191	9.	Birthpla Count Max	ace (Stete or Fo y) yland	oreign
	Director	}	Usual Residence of Decedent	7.	70				l,	<u> </u>	ray 29	, 132	21	rat.	ylanu	
1	Maryland -f show fied at		10a. State 10b. County		10c. Cit	ty, Town or L	ocation							10	d. Inside City L	
1	a-f st	ctor	MD Dorche	ester				Cam	brid	ge					1 XYes 2[□ No
3	with the a or 28a	by Funeral Director	10e. Street and Number				10f. Zi	p Code				10g. Cit	izen of What		ry?	
20	death w	rail	406 Shepherd A						21613				U.S.A		- 1- 0-	
260	tems	nue	11. Marital Status	12. Was Decedent Armed Forces? 1 X Yes 2		.S. 13.	. Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Or in, Mexicai	igin? (Spe n, Puerto I	cify Yes or No Rican, etc.))-	14. Race - A Bfack, V			
36	rs after F, or Re	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWI	ı	1 🗆 Yes	2 X No	Specify:	:			Specify:	wh.	ite	
9	72 hours		15. Decedent's			16a. Dece	edent's Usu	al Occup	ation	at of models		16b. K	ind of Busine	ess/Ind	ustry	
215	within 7. ene. than "n	pie	(Specify only highest g Efementary/Secondary (0-12)	College (1-4or	5+)	archi	DO NOT L	ise retired	1)		•				-	
21	filed wi Hygien Sther th	Completed	11				alist						ire cl	otn	mrg.	
pu	be fill d oth	Be	17. Father's Name (First, Middle, Las			-					(First, Middle		(Surname)			
Z a	should ind Men ind marke umatic	2	Wilbur S. Will			10h Mai	lina Addrac	s (Street :			Hurley Route Numb		or Town Stat	e Zin	Codel	
a A	d 2 st th and 7 Is n treun		Rebecca Willey				•	,			nbridge				<i>5000)</i>	
စ်	1 and Health tem 27 other tr		20a. Method of Disposition	*******	20b. F	Place of Disponentery, cre	osition (Na	me of	1		ete		ocation - City		vn, State	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Exacting main the notified at ances.		1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec							v 2/:	20/04	Fast	New i	Marl	ket, MD)
alti	permit. I Departm Importar any inju		21. Signature of Funeral Service Lic		Fub		22. Name a				omas Fu					
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760,	Examined cian and purial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	onsec	QUE	MOC C	((()	non	na				7	year	5_
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rds, P	w requires that the s been signed by the should be detach	þ	Part II. Other significent conditions	contributing to death t	out not res	sufting in the	underlying	cause giv	en in Part	l. 	23e. Did t		1		e cause of deat bly 4 □Unk	
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/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hereitel				0"		e of Death	(Check only	one)				
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n	ding I	lon	27. Manner of Death Natural 5 Pending investigat	(Month, Da	y Year)	Injury	м	28c. Injur Wor	k? Yes 2□		LOG. DOSCINO	110# 11110	ry occurred			
isi	Attending r death. ector: After by the fune	lica	3 ☐ Suicide 6 ☐ Could not	be One Blace of In	jury - At h	lome, farm, s					28f. Location (Street ar	nd Number o	r Rural	Route Number	r,
Div	ital or A	Certi	4 Homicide	building, e	tc. (Speci	fy)					City or To	wn, State	э)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examina	owledge, dea ation and/or i	ath occurred investigation	d at the tir n, in my o	ne, date a pinion, dea	nd place, a ath occurre	and due to the ed at the time,	date and) and manne d place, and	r as sta due to	ited. the cause(s)	
	To th To th comp	M	29b. Signature and title of certifier	200			29	c. Licens	e number			29d. Da	te signed (M	onth, D	ey, Year)	
			I lugere &	1 Wen	75	2	/	451	79	3		2/	19/0	+		
			30. Name and address of person wh	o completed cause of	death (Ite	m 23a) (Type	e, Print)	2 -	2	CL	0	10-	1	111	2211	1)
			31. Date filed (Month, Day, Year)	Jewmie 32. Regist	ras Sinn	ature	50	7 D	1450)]]	Cam	10/11	uge /	-(1)	016	1
4	Sta Regist		FEB	2 0 2004	Sagar.	L K	L	N/L								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 07902 State Registrar AMENDED 23a, 2/17/04, LDB, DOR Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer **Physician** 015 Woodland , 2004 1612 February 13 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore of Maryland Medical Center University If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months Hours Yrs. 1925 Maryland Director 214-28-**7**915 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Dorchester Cambridge Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Itams 23s or 5013 Plantation Road 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes. 2 □ No If Yes, Give Year or Dates: 1943-45 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 ☐ Divorced "natural" White Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner & Commercial Waterman Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If item 27 is marked oth any lipiury or other traumatic event sons. Be Theodore Woodland Irene Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina W. Seaman/Daughter 5013 Plantation Rd., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 2/17/2004 MD Veterans Cemetery Hurlock, MD ²², Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 21. July ure of Funeral Service Licensee Horas Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart failure Physician 15 years /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attending Physicisn: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 💢 No 1 Unpatient 2 ER/Outpatient 3 DOA this hours after death.

Inerel Director: After this y filled in by the funeral di 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Anatural
2 Accident 5 Pending 1 TYes 2 No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel C completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Jones, M.D. aliney 17664 tebruary 12, 2004

State Registrar hauncey

31. Date filed (Month, Day, Year) FEB 1

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004 32. Regular's Signature

Jones,

State of Maryland / Department of Health and Mental Hygiene 2004 07903 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:15 P M February 22, 2004 Francis Donald Wilkinson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans' Home Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | Min. | U I y 20, 1920 9. Birthplece (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 83 214-30-0513 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director Maryland Prince George's Brandywine 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ō or Nams 23a 17012 Milltown Landing Road 20613 USA death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1X☐Yes 2☐No 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene Important: if flem 27 is marked other than "natural; or Itan any injury or other traumatic event, the Medical Experiment Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Farmer Agriculture 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Francis Wilkinson Mary Helen Tippett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry M. Wilkinson - Brother 17012 Milltown Landing Road, Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State
4 Donation 5 Option (Specify) 2-27-04 St. Mary's Ch. Cem. Aquasco, MD 22. Name and Address of Facility
Huntt Funeral Home 21. Signature of Funeral Service Licey ee M01391 P. O. Box 156, Waldorf, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List drify one cause on each line. P. O. Box 156, Waldorf, MD 20604 Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) INFARCTION MYOCAMPIAL **Physician** /Medical Due to (or as a consequence of): **Examiner** ARTERY DISTASE CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ NONINSULIN DEPENDENT DIABETES MEZLITUS 1 Yes 2 No 3 Probably 4 Unknown as been sig Be Completed ATPLAC FIBRICEATION. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an has autopsy performed? HYPERLIPINEMIA, RENAL INSUFFICIENCY After this certificate 2.0 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred s after dea. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50963 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARCOTTE HALL. 32. Redistrar's Signature 31. Date filed (Month, Day, Year) FEB 2 4 State 2004 Registrar

		Pleas	e Type or Print				-	_	ole.	
		1 - State	State of Ma	ryland / Depa <i>Ce</i>	artment of F rtificate of I			Reg. No. 20	04 0	7904
		1. Decedent's Name (First, Middle,	Last)				2. Date of Dea		3. Ti	me of Death
Physi /Med		Helen Lucile Woo					February	7 16 2	004	3:00 PM
Exam		4a. Fecility Name (If not institution,				r Location of Death	h	4c. County	of Deeth Gton Cou	m+
		Washington Count 5. Social Security Number 6	Sex 7. Age	(In yrs. last birthday)	Hagers If Under 1 Year	II Under 24 Hrs.	8. Date of Birt		9. Birthplece (S Country)	
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and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Ins	ide City Limits
Maryl -f eho	ţō	Pennsylvania	Franklin	Waynesb	oro				10	Yes X No
3e or 28e	Il Directo	10e. Street and Number 11992 Gehr Road			10f. Zip Code 1726	8		10g. Citizen of W		
ING Z I Z I 35-UUSO be filed within 72 hours after death with the Maryland stal Hygiene. nd other then "natural", or stems 23a or 28e-1 show event, the Madical Exammer must be coulded at	by Funeral	11. Marital Status 1 Never Married 2 A Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	tispanic Origin? (S an, Mexican, Puerl Specity:	pecify Yes or No- o Rican, etc.)	- 14. Race Blac Specify	- American Indi k, White, etc. White	an,
72 ho	eted	15. Decedent's (Specify only highest		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	rking	16b. Kind of Bu	siness/Industry	
within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retired Homemaker			Persona]	Resida	nce
filled wither the	e Co	12 17. Father's Name (First, Middle, La	ist)		IOIRCII		me (First, Middle,			
Should be file of Mental Hymarked oth	To Be	John W. Ringwale	£			Bessid	or Juday	•		
Man d 2 sh dh and 7 is m traum		19a. Informant's Name/Relationshi Robert R. Glenn			ng Address (Street 992 Gehr					
baltimore, permit. Pages 1 and Department of Healt Important: If item 2 eny Injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		20b. Place of Disponent Competery, cre	osition (Name of matory or other plac ra Cremat	ory	Date S	20c. Location - Smithsbur	City or Town, Story	
Saltir ermit. P epartme nportan ny Injur	e e	21. Signature of Funeral Service Li		3	2. Name and Addre		ouglas A	_		
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6U, be executed sicien and burial-transit	al Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of);						
GO/ ifficate g phys	edic		d		0100					
death cert e attendin of for use	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date Mor	e of delivery oth Day	Year
- 2 P B	Phy	Part II. Other significant condition	s contributing to death bu	t not resulting in the t	underlying cause giv	ren in Part I.	23e. Did to	obacco use contr	ibute to the caus	e of death?
uires that uires that signed to	d by	Hyperte	nsion				101	Yes 2□No	3 Probably	4 ∑ Unknown
Mecords, The law requires the has been signed age 2 should be on	Completed						24a. Was	an 24b. V	Vere autopsy fin	dings available
r ege	E						autop perfo 1 Yes	rmed?/ d	rior to completio eath? ☐ Yes 2☐ N	
VITAL I	Be	25. Was case referred to medical examiner?					ath (Check only o	one)		
Of VITAL Physicien: 1 rthis certifical ral director, p	မ	1 ☐ Yes 21 No	Hospital: 12 Inpatier		IR 3 DOA		dome 5 Resid	dence 6 Othe		
C 6 3 8	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investige	(Month, Day	Year) 28b. Time of Injury	Wor	yat rk? Yes 2 □No	20d. Describe i	now injury occurs	eu .	
DIVISION of or Attending safter death. I Director: Attending to by the fune	Certification;	3 Suicide 6 Could no 4 Homicide determin	ot be Ope Place of Injur	ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Numbi wn, State)	er or Rural Route	Number,
Hospit. 4 hours Funers	Medical C		Physician: To the best of xaminer: On the basis of and manner stat	examination and/or in						use(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed		
		Mr.	Ur	11	D005	0813		reb.	16, 200	4
DH.7		30. Name and address of person w		,		2 11		1	24.5	
	State	Neil O'Malley 31. Date filed (Month: Pay: Year)	1150 Profess	r's Signature	1	: Hagerst	own, Mar	yland 2	21740	
	strar	31. Date filed (Month, Pay, Year)	2004 Asker	a D. A.	perte					

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artmen rtificat			nd Me		ene g. No.2 (004	079	05
	Physici /Medio			Marshall	WALLING					Date of Death Month February	Day 19	Year 2004	3. Time of 0	
	Examir	er	4a. Facility Name (If not institution, give s Washington County	Hospital		Hag	erst			<i>(</i>		ty of Death hingto		
	Funeral Director		213-42-3403	7. Age	(In yrs. last birthday, 59 Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, uly 22,	1944	9. Birthp Coun Mary	lace (State or try) Land	Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Washingto		10c. City, Town or L Hagersto			-			•	1	0d. Inside City 12∑ Yes	
	a or 28a	Funeral Director	10e. Street and Number 62 Randolph Avenu	ıe		10f. Żip		1740		10	g. Citizen of	What Coun	try?	
980	d within 72 hours after death with the Maryland Jiene. r then "natural", or Items 23s or 28s-1 show Itte Medical Exarts actional be inciffied at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	ver in U.S. 13. 1966-1968	Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)	Bla	ace - Americ ack, White, ify: Whi	etc.	
Maryland 21215-0036	within ene. then	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 0-10		(Give	edent's Usua e kind of wo DO NOT us umber	rk done d se retired	during most)	of working	1	6b. Kind of E		compan	ıy
land 2	be filed stat Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) Charles	Walling				18. Mother		First, Middle, M				
	s 1 and 2 should Health and Men item 27 is marks other traumatic		19a. Informant's Name/Relationship (Type Janice Walling - W			-				doute Number. gerstown				0
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Rev. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License			matory or of awn lorial 2. Name ar	Par Par Id Addres	k Facility			neral	town, Home	Maryla	
8760,	tate be executed hysician and hysician and the burial-fransit in t	ilcal Examiner	23a. Par1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a	spiral confequence of): detast	alie	e of dying	X Luy	Ceen	aspiratory arres	st,		Approximate Interval Betw Onset and Do	reen .
P.O. Box 6	that the death certifica ed by the attending ph detached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Petal death 3	⊒Ectopic pr ⊒ Other (sp						ate of delive		ear
	Se De G	by	Part II. Other significant conditions con	- []	t not resulting in the u	underlying c	ause give	en in Part I.		23e. Did toba			e cause of de ably 4 □Ur	
I Records,	The ate h page	Completed	Chrone	ue obs	Lucture	2 00	eng	Dis	eale	24a. Was an autopsy perform	ed?	prior to con death?	osy findings av	vailable use of
Vita	sician: certific rector,	o Be (25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	t 2 ER/Outpatie	-t 2C 05	Othe	100		Check only one		/0 /		
Division of Vital	Jing After fune	I -	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day			8c. Injury Work		280	5 Resider d. Describe hov			/	
Divisi	al or Attanding s after death. il Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory	, office		28f	Location (Stre City or Town,		ber or Rura	Route Numb	ΘΓ,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	sician: To the best of ner: On the basis of e and manner state	examination and/or in	th occurred ivestigation	at the tim , in my op	ne, date and pinion, death	place, and h occurred	I due to the cau at the time, dat	use(s) and m te and place,	nanner as st , and due to	ated. the cause(s)	
•	To th within comp	Me	29b. Signature and title of certifier	'ede_		290	DQ	number S9	8	29	d. Date signe	ed (Month, L	Day, Year)	
5	×12			mpleted cause of de	ath (Item 23a) (Type, ADE 3.	Print)	416	L 57.	HAE	GERSTO	RUN)	402	1740	
	Sta Regista		31. Date filed (MoFEB 23 200	32. Flegistrar	's Signature	ed)								

State of Maryland / Department of Health and Mental Hygiene 2001 07906 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1243 PM JOAN KATHERINE WENKER 2 2004 19 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ocean Pines 11 Watergreen Lane Worcester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 9/7/1934 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 XF 219-30-0444 69 MD Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County in than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 1 XYes 2 No Director MD Worcester Ocean Pines 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11 Watergreen Lane 21811 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vient of Headla had Mental Hygbene.
ant: If item 27 is marked other than "ratural", or items 23a may or other traumatic event, it a Marical Examination in the hadron of the manual or 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ▼ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personnel Director Mutual Fund Co. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Norman S. Holbrook Margaret Nickoles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna Leiner 13044 Northshore RD Ocean City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Department of F Importent: If its any injury or ot Maurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 2/23/2004 Berlin, MD 22. Name and Address of Farine Burbage Funeral Home permit. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on 108 William St. Berlin, MD Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy Year ō Month 5 ☐ Other (specify) detached 9☐ Unknown 9 Unknown 23e. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 1 NO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 / No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) Medical Certification: To 1□Yes 2□Mo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 I Homicide Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) augh 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State 23 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001

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	•	State Registrar				Ce	rtificate of	Death			Reg. N	lo.	~ 1	0100
		1. Decedent's Name (First, Mid	dle, Las	it)						2. Date of Month			V	3. Time of Death
Physicia /Medica		MARC	ARI	ЕТ НО	PE WH	ARTON				2		1 7	Year 2004	5:03A M
Examine		4a. Fecility Name (If not instituti				10.10	4b. City, Town, o	or Location of I	Death		4	c. County	of Death	0.007.
		Gull Creek	Ret	iremen	t Cent	ter	Berli	in				Word	ester	-
Funeral Director		5. Social Security Number 220-20-8189	6. Se	9x □M 2 X F	7. Age (In y	rs. last birthday Yrs.	Months Days	If Under 24 Hours	Hrs. Min.	B. Date of I (Month, 6/1/	Birth Pay Yea 1920			ace (Stete or Foreign
g		Usual Residence of Decedent												
death with the Maryland ms 23e or 28e-f show crists be notified at	ō	MD Wor	•	.	10c.	City, Town or L							10	od. Inside City Limits 1 XYes 2 □ No
the M 28a-f	Director	MD Wor	ces	ter		Ocea	n Pines				10- 0	101a - a - d 10		
with			- C								-		hat Count	try?
eath w	era	4 Heron Isl	e C		cedent Ever in	115 13	218		2 (6000	du Vac ar I		USA	e - America	a ladian
<u>ĕ</u> ≗ ≅ .	by Funeral	1 Never Married 2 Ma 3 Widowed 4 Divorce		Armed F	orces? 2 XNo ive	10.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	Specify:	Puerto Ri	ican, etc.)	10-	Blac	k, White, e	otc.
72 hours "natural", Olcal Ex		15. Decede				16a. Dece	ident's Usual Occup	ation			16b	Kind of Bu	siness/Ind	ustov
C 2	Completed	(Specify only high Elementary/Secondary (0-12)	-		(1-4or 5+)	(Give	kind of work done of DO NOT use retired	durina most o	f working	7				aoti y
d with	E	Lienteritary/36condary (0-12)		4	(1-40/ 5+)	Ath	etic Dire	ctor			S	chool	Sys	tem
# I B E	0	17. Father's Name (First, Middle						18. Mother's	Name (First, Midd	le, Maide	n Sumam	9)	
	0 0	Ira C. Whar	ton					Mar	⁻y J	. Ada	ams			
s 1 end 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relation	ship (T	ype, Print)		19b. Mail	ng Address (Street	and Number	or Rural i	Route Num	ber, City	or Town,	State, Zip (Code)
C = 44 P		John Noon				144	Jefferso	n RD	Prin	ceton	. N.	J 08	540	
vernit. Pages 1 el Department of Hea mportant: If Item iny injury or othe		20a. Method of Disposition			20t		TEMPETON YIAC		Dat		-		City or Tow	vn, State
80=5		1 XBurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other					irew's Ep		2/2	0/04	Pri	ncasi	s Anr	ne MD
permit. Par Depirtmen Important: any injury ance	1	21. Signature of Funeral Service												
permit. Depart Imports any inj	ļ	* YORA HALL	20		10110	. 4	2. Name and Addres	The	Bui	rbage	Fur	neral	Home	е
	+	73a. Pert1. Enter the disease,	or comp	lications that	caused the de	ath Do not en	08 William	1 SI. E	diac or i	n, MI	D 2	1811		Approximate
4 2	1	snock, or nead randre. Li	t only o	one cause on	each line.	90 1101 611	to the mode of dyar	ig, such as ca	rolac or i	espiratory	arrest,		1	Interval Between Onset and Death
Physician	1	Immediate Cause (Final disease or condition resulting in death)	_	a non	SMB	ll cel	l luno	Ca	MCO	N				7/2002
/Medical Examiner	- 1	resulting in death)		Due to	(or as a cons	equence of):		\						
		Sequentially list conditions,		b	W Po	The second secon	emia						-00	1005
D = 1	9	If any landing to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to	(or as a cons	equence of):								(
acute and trans	Examiner	that initiated events		c	HYA	erter	sion							sounda
e exe		resulting in death) Last		Due to	(or as a cohs	equence of):								1
certificate be executed tding physicien and ise as the burial-transit	medical			d	[no	whia								72003
tifica ng ph as th	De l													
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physicianin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Do		1 ☐ Live	itcome of preg birth 2 Fe nant at time o	etal death 3	Ectopic pregnancy Other (specify)					23d. Date Mon	of delivery	y Day Year
hat the deby detacl	5	Part II. Other significant condit	ions co	entributing to a	leath but not r	aculting in the	ndarking cause awa	on in Part I		220 Did	tabassa			cause of death?
signe d be	9	•				osaking in the s	ridonying cause give	ori ai r cai (i.		1			3 ☐ Probai	
w requir been si should					-				-	1				
ding Physician: The law requires the fact this certificate has been signe funeral director, page 2 should be	completed								-	24a. Wa aut per 1 ☐ Yes	s an opsy formed?	Pr	ere autops for to comp eath? Yes 2	sy findings available pletion of cause of
s certificat		25. Was case referred to medic examiner?	al					26. Place of	Death (0					10000
Physician: rthis certific ral director.		1 ☐ Yes 2 ☐ No		Hospital: 1 🔲	Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	er: 4 🗆 Nursir	ng Home	5 □ Res	sidence .	6 The	(Specify)	13313 K
for Attending Physalter death. Director: After this in by the funeral d		27. Manner of Death		28a. Date	of Injury oth, Day Year)	28b. Time o	28c. Injury Work	at	286	d. Describe	how in			LIVING
Attending r death.	3	1 ☐ Natural 5 ☐ Pend 2 ☐ Accident inves	ng igation	(10101	in, Day rour	injury		Yes 2 □ No)
Atte	2	3 Suicide 6 Could 4 Homicide deter	not be	28e. Place	e of Injury - At	home, farm, str	eet, lactory, office	10-10-	281	. Location	(Street al	nd Numbe	r or Rural I	Route Number,
tel or Attending P ss after death. el Director: After led in by the funer	2	4 Homeda	1	Dulia	ling, etc. (Spe	city)				City or 1	own, State	9)		
	Medical	29a. Certifier 1 Oertify (Check only one) 2 Medice	ng Phy I Exami	sician: To the	e best of my k easis of exami	nowledge, deat nation and/or in	n occurred at the tim vestigation, in my op	ne, date and p	lace, and	d due to the	e cause(s	and man	ner as stat	ted. he cause(s)
o the	Σ _	29b. Signature and title of sertifi		und mar	JIBIOU.		29c. License						(Month, Da	
- 3 - ŏ			().	0			110	01-1-	2011			2 1 7	~ / I	-,, / Oui/
		- W	Ll	V		1	MO	こりか	141		- "2		40.	
4 7		30. Name and address of person	who co	ompleted cau	se of death (It	em/23a) (Туре,	Print)							
i i		Dr. Dek				ld Ocea	n City R	D Ber	lin,	MD	2181	1		
State		31. Date filed (Month, Day, Year	0 20		egistrar's Sig	nature	and a							
Registra		1 1 2	A CI	JU4 JU	Leve	15 /6/2	RIVEL S							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 **Physician** 17, FEB. YANMING WANG 12:15 № /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 28, 1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1XM 2□ F China 214-59-7696 70. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show confised at MD Montgomery Gaithersburg Director 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ad other than "natural", or items 23a or event, the Medical Examiner must be 14817 Dufief Mill Road 20878 CHINA . by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes **2√3**No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Chinese 3€ Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tianjin Steel Elementary/Secondary (0-12) College (1-4or 5+) Engineer parmit. Pagas 1 and 2 should ba filad w Department of Health and Mental Hygien Important: If Item 27 is market other th any injury or other traumeric 4 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 8 7 8 19a. Informant's Name/Relationship (Type, Print) 14817 Dufief Mill Rd., Gaithersburg, MD Mei Wang (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ 80rial 2 ○ Cremation 3 □ Removal from State Metro Funeral Srv 2/22/04 Alexandria, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signat re of Funeral Service Licens 246 N. Wash. St., Rockville, MD 20850 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Aspiration Pneumonia 3号 months /Medical Due to (or as a consequence of): Examiner Stroke 3½ months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☐XNo Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide cal 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AND Feb. 17, 2004 D58681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 Jude R. Alexander, 9901 Medical Center Dr., Rockville, MD M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 20 oaks! FEB 2004 Registrar

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:35P February 17, 2004 Vada Lee Wheeler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 413-42-6882 Feb. 26,1929 Director 74 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Montgomery Gaithersburg Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 With United States or items 23a 20878 915 Clopper Road; Apt. T-4 by Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury og other traumatic avant, the Managones. Elementary/Secondary (0-12) College (1-4or 5+) 12 Television and Radio Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nell Ledington George Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald C. Wheeler/Spouse 915 Clopper Road; Apt. T-4; Gaithersburg, MD20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Loudon Park Crematory 02/26/2004 Baltimore, MD 21. Signature of Funeral Service License Simple Tribute Funeral and Cremation Center lly 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): **Examiner** Anoxic Encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit certificate be executed and Due to (or as a consequence of) been signed by the attending physicien should be detached for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 🗌 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 ∏Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2**X** No ospital or Attending Physician: Thours after death.
uneral Director: After this certificatily filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide To the Hospital within 24 hours a To the Funeral D Positiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifige 29c. License number D58681 Februar 17, 2004 30. Name and a ress of person who complete cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive; Rockville, MD 20850 Jude R. Alexander, MD 31. Date file (Month, Day, Year) FEB 2 4 2004 32. Registrar's Signature State enera Registrar

			1 - For State Registrar		State of	Marylan	id / Depa	artment o	of He	alth and M eath	lental Hy	giene Reg. No.	2004	07910
			1. Decedent's Name (First,	Middle, La	st)					_	2. Date of De Month	ath Day		3. Time of Death
V	Physici /Medic		Erman	Ha	ynes	Whi	te				Feb. 2			5:00ам
	Examin		4a. Facility Name (If not ins	titution, giv	e street and num	iber)		4b. City, Tov	vn, or Lo	ocation of Death		4c.	County of Death	
			Cresthav	en N	Jursing	Home				r Sprin			ontgom	ery
	Funeral		5. Social Security Number	6. 5	Sex DXM 2□F	7. Age (In yrs.		If Under 1 Y Months D		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 3 / 18	th y, Year)	9. Birth Coa	place (State or Foreign intry)
	Director		079-18-8136 Usual Residence of Decede)	ZIM ZUI	80	Yrs.				3/18,	/192	3 N.Y	N.Y.
	and w		10a. State 10b. C			10c. Cit	y, Town or Lo	cation			-			10d. Inside City Limits
	Manyl 1 sho	ō	D.C.			Wa	ashin	gton						Yes 2 □ No
	28e	rect	10e. Street and Number			1		10f. Zip Co	de			10g. Citiz	zen of What Cou	untry?
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	death ms 2	Jera	11. Marital Status		12. Was Dece	dent Ever in U	.S. 13.			panic Origin? (Spe Mexican, Puerto	cify Yes or No		14. Race - Amer	
9	after or ita	Ē	1 Never Married 2] Married	Armed For	2 🔯 No		nr Yes, speciny (1 □ Yes 2 🔄		Mexican, Pueπo Specify:	Hican, etc.)		Black, White	
93	72 hours after death with the Maryland natural, or Itams 23a or 28e-f show dical Examinations to collined at	1 by	3 ⊠Widowed 4 □ Div	rorced	If Yes, Give Year or Da	tes:		10 105 20	NO .	эрөспу.			Specify: B.	lack
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			shock, or heart failure Immediate Cause (Final	. List only	one cause on ea	ich line.								Interval Between Onset and Death
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68	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the											I		
Вох	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregna		23c. If yes, outc	ome of pregna		Ectopic pregn	ancv			2	3d. Date of deliv	•
	the att	icis	in the past 12 months 1 ☐ Yes 2 ☐ No	?		int at time of de		Other (specif)					Month	Day Year
P.0	at the de by the a	h,	9 🗆 Unknown											
S,	signed of	by	Part II. Dther significant co	onditions o	ontributing to dea	ath but not resi	ulti ng in the u	nderlying cause	given i	in Part I.	23e. Did to	obacco us	se contribute to t	the cause of death?
ord	w requir been si should										101	res 2∟	No 3□Pro	bably 4∑Unknown
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sio	tand leath tor: /	cati	E	nvestigation Could not be						s 2 □No				
Division of Vital Records,	or At fter of Diraci in by	Certification;		letermined	28e. Place	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str v)	eet, factory, off	ice		28f. Location (3 City or Tov		l Number or Run	al Route Number,
	pital		On Cariffic 4F3Ca	dificio a Dh	veision. To the l					<u>+</u>				
	To the Hospital or Attanding within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 XCe (Check only 2 Me	dical Exen	ysician: To the t niner: On the bas and manne	sis of examinat	wiedge, death tion and/or in	estigation, in n	ie time, ny opini	date and place, a ion, death occurr	and due to the a ed at the time,	cause(s) a date and p	and manner as s place, and due t	stated. o the cause(s)
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	5		30. Name and address of p	arson who	completed cause	of death (Item	23a) /Tune	Print)					2/2	
			Kirti Vchr						Bt (ethesda	a. Md	2081	7	
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			for State Registrar	State o	f Marylan	nd / Depa <i>Cei</i>	artmen <i>tificat</i>	t of He e of C	ealth a Death	ind M	ental Hy	giene Reg. No.	200) 4	079	11
			1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	Y	ear	3. Time of De	ath
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	Examin		4a. Fecility Name (If not institution, given	e street and nui	mber)		4b. City,	Town, or I	Location o	f Death		4c.	County of I	Death		
			Washington Advention Social Security Number 6.5		pital 7. Age (In yrs.	last hirthday)	Tal		Park If Under	24 Hrs.	8. Date of Bi		ntgon		ce (State or Fo	oreian
	Funeral Director			_M 2√2 F	7. Age (117 y/s.	Yrs.	Months	Days	Hours	Min.	June 2	y, Year)		Count	sota	or orgin
			585-07-6890 Usuel Residence of Decedent		7.5						June 2	7,17	50 M			
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside City L	
	e Mar	ctor	Maryland Montgo	nery		Silver									1 □ Yes 2[****
	or 28	Directo	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of Wha	at Count	y?	
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, 'q			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	plications that of	caused the dea	th. Do not ent	er the mod	le ol dying	, such as	cardiac o	r respiratory a	rrest,	•		Approximete interval Between	en
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	/Medical Examiner		resulting in death)	Due to	(or as a consec	quenee of):	بمب		1			~~				
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οt			27. Manner of Death	28a, Date	*	28b. Time o	f 2	28c. Injury Work	at ?		28d. Describe	how injur	y occurred			
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	o the	Me	29b. Signature and title of certified	1/			29	c. License	number		T	29d. Dat	e signed (M	Month, D	ay, Year)	
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	1>		30. Name and address of person wh	completed cay	se of death (Ite	m 23a) (Type.	Print)	Je.	- /				1	1	*	
			DR. ANJun &	DAZY	7610	CARR	011	AUG	IA	Kom	n Pan	k, 1	no	21	912	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			State of Maryl	•	artment of F rtificate of		-	giene Reg. No. 2 (nnı.	07010
	Physician	1. Decedent's Name (First, Middle, La					2. Date of De Month	ath Dey	Year	3. Time of Death
3	/Medical Examiner	Ruth Elizabet 4a Fecility Neme (If not institution, giv	h William e street end number)	.S		4b. City, Town, o	Februa r Location of Deat	ary 12,		8:40 pm
	uneral	Manor Care - Ch 5. Social Security Number 6. S		rrs. lest birthdey)		Chevy Ch	s. 8. Date of Bir	Mont	gomery 9. Birthpla	ce (Stete or Foreign
	irector	577-28-7774 Usuel Residence of Decedent	82	Yrs.			Oct. 4		Virgi	,,
Marylend	f show led at	10a. State 10b. County DC		City, Town or Lo					100	d. Inside City Limits 1√□ Yes 2□ No
th the	be notified Director	10e. Street end Number	V	<u>Vashingt</u>	On 10f. Zip Code			10g. Citizen of	Whet Country	**
ath wi	ral C	4415 Greenwich P	arkway, NW		2000	07		USA		
5-0020 72 hours efter death with the Marylend	al', or items 23a Examiner must by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:	1	Was Decedent of H f Yes, specify Cube I □ Yes 2덨 No	dispenic Origin? en, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)	- 14. Rad		
Maryland 21215-0020 td 2 should be filed within 72 hours eff the end Mentel Hygiene.	Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Experience must be notified at once. To Be Completed by Funeral Director	15. Decedent's Ec (Specify only highest gre Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done OO NOT use retired	ation during most of w	orking	16b. Kind of B		
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ylar Vuld by Mente	atic e.	Daniel L. Border	1			Marga	ret C. So	nrrel1		
Mar 12 sho hend	r Is m traum	19a. Informant's Name/Relationship (1		19b. Mailin	g Address (Street	and Number or I	Rurel Route Numbe	er, City or Town,	State, Zip C	ode)
Baltimore, I sermit. Peges 1 end Sepertment of Healt	or other	Stephen A. Borden 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Demovariioni State 12 -	 Place of Disposition Completely, cren 	loudberr sition (Name of natory or other place apel Ceme	e)				nd 20866 n, State
altin nit. P	Injury B.	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	/	22	Name and Addres	ss of Facility	02/17/04			inia
n ga	any le	pho 8	. Hank	Fra	ancis J.	Collins	Funeral	Home,]	Inc.	
hys	sician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the de one cause on each line.	eath. Do not ente	er the mode of dyin	g, such as cardia	d.,W.,Sil	rest,	A In	pproximate pterval Between inset and Death
	edical miner	Immediate Cause (Final disease or condition resulting in death)	a Cardiopulm	onary Ar					Imn	nediate
cuted	rensit	Sequentially list conditions	_{b.} Carcinoma		tastatic				2_	years
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Certifice	000 =	resulting in death) Last	_{d.} Dementia	(0) 40 0 0013040					6	months
g egg	e atte	Part II. Other significant conditions co	ntributing to death but not r	esulting in the un	derlying cause give	en in Part I	23b. Did to	obacco use cor	atribute to th	e cause of death?
requires that the deeth cer	been signed by the attendin should be deteched for use leted by Physician/N		•							oly 4 ∰Unknown
is di	20 0						24a. Was a perfor	an autopsy med?	availa	autopsy findings ble prior to letion of cause ath?
1 Pe .	r, peg						TOY	es 2 X No	1 🗆 Y	es 2 No
Physician:		25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No	Hospital: 1 ☐ Inpatient 2	☐ ER/Qutpatient	3D DOA Othe		ath <i>(Check only or</i> Home 5 ☐ Resid		- 10	
Attending Phy	: After this certificete he funeral director, page atlon: To Be Com	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h			
Hospital or Attended to the Hospital or Attended to the Hours of the deat	The Funeral Director: After this calletely filled in by the funeral directors of the funeral directors.	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (S. City or Town	treet and Numbe n, State)	er or Rural Ro	oute Number,
he Hospi in 24 hou		one) 2 Medical Exami	sician: To the best of my kr ner: On the basis of examir and manner stated.	nowledge, death nation and/or inve	occurred at the timestigation, in my op	e, date and place inion, death occ	and due to the curred at the time, d	ause(s) and ma ate and place, a	nner as state and due to the	d. e cause(s)
To the within	Z Com	29b. Signature and title of certifier	m) 1	M	29c. License	number	2	9d. Date signed	(Month, Day	', Year)
6	•	30. Name end eddress of person who co	ompleted cause of death life	em 23a) (Type. P	_ D 5928	31	F	ebruary	14, 2	004
		Ishtiaq A. Malik,	0.05			sville.	MD 2086	6		
®.	State legistrar	31. Dete filed (Month, Day, Year) FFB 1 7 200	32. Registrar's Sign	nature £	Sports	-				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Month **Physician** FEB. 15 E. WILLIAMS 2004 10:35 THELMA /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital MONTGOMERY Silver Spring If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Dec. 4, 1917 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1□ M **%**□ F 86 Maryland 217-14-7244 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural; or Itame 23a or 28e-f show any jury or other traumatic event, the Mudical Examiliter must be notified as once. 10a. State 10b. County 1 Yes 2 □ No Director MD Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895 3910 Hampden Street U.S.A. by Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th College (1-4or 5+) Domestic Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carrie L. Smothers Charles H. Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Raymond Thomas (Son) 3910 Hampden St., Kensington, MD 20895 Baltimore, 20b. Place of Disposition (Name of competery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Ash Memorial Cem. 2/23/04 Sandy Spring, 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Lic insee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 Legige 23a. Part1. Enter the disease, or complications that caused the death. Up not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Peritonitis /Medical Due to (or as a consequence of): **Examiner** Sigmoid Colectomy Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Colovesical Fistula the burial tran Due to (or as a consequence of): P.O. Box 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No į 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, sign i be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Urosepsis Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 : autopsy performed? 2∏ No. 1 Yes 2 No 1 Tyes certificate Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check on one Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _ 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To After thi 28b. Time ol Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funarel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Signature and fittle of certifier D52261 Feb. 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Segal, M.D 1299 Lamberton Dr., Silver Spring, MD 20902 31. Date liled (Month, Day, Year) 32 Registrar's Signature State FEB18 2004 Registrar

		State of Maryland / Dep 1 - State Registrar AMEND#15perINF2/23/04, BMW, McCo Ce	partment of Health and Mer ertificate of Death	Ital Hygiene 2004 0	7914
Physic /Med		1. Decedent's Name (First, Middle, Last) Ruth C. Wallace		Month Day Yeer Sebruary 12, 2004 3:	ne of Death
Exam	iner	4a. Facility Name (If not institution, give street and number) 2815 Lindell St.	4b. City, Town, or Location of Death Wheaton	4c. County of Death Montgomery	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 M 2 St F 84 Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Year) 1-26-20 9. Birthplace (Standard) Country) NY	ate or Foreign
iryland show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		de City Limits Yes 2 ☑ No
ith the Ma or 28a-f	Director	MD Montgomery Wheaton 10e. Street and Number 2815 Lindell St.	10f. Zip Code 20902	10g. Citizen of What Country?	
Baltimore, Maryland Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or Items 23s or 28s-f ehow any injury or other traumatic event, the Medical Exprising must be notified at	by Funeral		3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 ☒ No Specify:		n,
Z1Z13-UU30 d within 72 hours aft giene. er then *natural; or the Wedical Exem	Completed by	15. Decedent's Education (Specify only highest grade completed) (Gillementary/Secondary (0-12) College (1-4or 5+)	sedent's Usual Occupation we kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry	
and 7.1	Be Con	17. Father's Name (First, Middle, Last) Unknown	istered Nurse 18. Mother's Name (F Ruth Buck	Medical irst, Middle, Maiden Sumame)	
Maryland nd 2 should be file th and Mental Hy 27 le marked oth	2	19a. Informant's Name/Relationship (Type, Print) 19b. Ma		oute Number, City or Town, State, Zip Code)	
Baltimore, bermit. Pages 1 ar Department of Hea Important: If item:	,	1 Burial 2 Micremation 3 Linemoval from State	position (Name of rematory or other place) Park Crem. 2-16-0		te
Balti permit. Departm Imports any inju		Inam a Capelle	11800 New Hampshire A	es-Rinaldi F. H. we. Silver Spring, M	D 20904
Medica Wedica Wedica Aysician and Aysicia	ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not display the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and least 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		li if di Ad	il Between and Death
I HECOTGS, P.O. BOX 58 The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day	Year
dS, F. juires that I n signed by	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause 1 Tyes 2 No 3 Probably	
	Completed			24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy find prior to completion death?	n of cause of
on of Vita ing Physician: After this certific uneral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at 28c	theck only one) 5 Residence 6 □Other (Specify) Describe how injury occurred	
DIVISION al or Attending atter death. Director: Atter d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		Location (Street and Number or Rural Route City or Town, State)	Number,
DIV To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b.	edicai C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, do not be the control of the dasis of examination and/or and manner stated.	eath occurred at the time, date and place, and investigation, in my opinion, death occurred	at the time, date and place, and due to the car	
4	M	29b. Signature and title of certifier	29c. License number D05969	29d. Date signed (Month, Day, Ye 2-13-04	ar)
7		30. Name and address of person who completed cause of death (Item 23a) (Type 8808 Hidden Hill Ln. Potomac, MD 20	pe, Print)		
Regi	State strar	31. Date liled (Mooth Pay, Year) FEB 1 9 2004 32. Begistrar's Signature	Sparks		

		•	1 - For State Registrar	State of Maryland	Depa	rtment of I	Health and Death		giene Reg. No.		0791	5
П	Observated		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day	/ Year	3. Time of Death	
	Physici /Medic		Camille Anita	Wallace				Februar	y 21	, 2004	4:55 P M	1
7	Examin		4a. Fecility Name (If not institution, give s			4b. City, Town, o	or Location of De	path	4c.	County of Death		
			Washington Adven				a Park			ontgomer		
	Funeral		5. Social Security Number 6. Sex	M 217 F	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	in. (Month, Da)	, Year)		place (State or Foreign intry)	n
	Director		219-48-6050 Usual Residence of Decedent	63	115.			May 6,	194	0 Can	ada	
	and w		10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside City Limits	
	f she	ō	Maryland Montgome		11,,,,	. Contro					1 ☐ Yes 2√∑ No)
	288 288	Directo	10e. Street and Number	:1y 5	TIVE	Spring			10g. Citi	izen of What Cou	intry?	
	ath with the Marylar 23e or 28e-1 show	0	304 Wayne Avenue	•		20910)			USA		
	hours after death with the Maryland tural; or Itama 23a or 28a-f show at Examination and be nutilial at	Funerai		2, Was Decedent Ever in U.S.	13. \			(Specify Yes or No- erto Rican, etc.)		14. Race - Amer		_
9	or Ita	F	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☒ No		Yes, specify Cub ☐ Yes 2√2 No		erto Rican, etc.)	-	Black, White	111	
9	rall,	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		LITES ZXINO	эрөспу.			Specify:Whit		
21215-0036	d within 72 hours after der giene. r than "natural", or Itama tha Medical Examiner m	Completed	15. Decedent's Educ (Specify only highest grade		(Give	ent's Usual Occup kind of work done	during most of w	vorking	16b. Ki	nd of Business/Ir	ndustry	
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and and	ntal H	Be	17. Father's Name (First, Middle, Last)									
Maryland	Mel Mel	٦ و	Rene Imbeau	on Chinal	Oh Maille	- Address /Ctmar		abelle Lai			- Codel	_
<u>a</u>	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Typ					Rural Route Numbe				
	1 and 1 Health Mm 27 ther tr		William E. Wallac 20a. Method of Disposition			ayne Ave	nue, Si	lver Sprin		MD 2091(cation - City or T		-
Baltimore,	Pages nent of unt: If Its		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	come	etery, cren	natory or other pla	Fe Fe	bruary 24				
	permit. Pag Department Important: eny injury once.	74	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		poli	tan Crema	tory				Virginia	-
Ba	permit. Pages Department of Important: If I eny injury or once.		21. Signature of Full dial Service Cicense	///	Fr	ancis J.	Collin	s Funeral	Hon	ne Inc.	000	
6			23a. Part1. Enter the disease, or complic	cations that caused the death. (vd. W., S		er Sprin	MD 2090	ĴΤ
			shock, of heart failure. List only on Immediate Cause (Final	e cause on each line.	100		2/2/	600-1	11		Intervat Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	unu	XI		rillep	Mulop	ar	ry		_
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e on		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ce of):	1	011	cco, n	4//	101		\dashv
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oʻ	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as a consequent	ce of):							
1760	ate be executed hysician and the burial-transit	icai	C _a				· .					
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Box	death certifica e attending ph d for use as th	Physician/Med	23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnanc	y		:	23d. Date of deliv		
	0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 9 Unknown		Other (specify) _	,			Month	Day Year	
о. О	The law requires that the de ste has been signed by the a page 2 should be detached	Phy	9 Unknown									\dashv
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ū	the line	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time of Injury	28c. Inju Wo	rk?	28d. Describe h	ow injur	y occurred		
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	Hos 24 ho Fun stely	edicai	(Check only 2 Medical Examin	ician: To the best of my knowle- ier: On the basis of examination and manner stated.	and/or inv	restigation, in my	me, date and pla opinion, death oc	ccurred at the time, c	tate and	and manner as i place, and due i	o the cause(s)	
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	5		30. Name and ediress of person who co	mpleted cause of death (Item 23	a) (Type	Print)	1019			-10-11	2/00	
			DR. NASKEEN				A.)	· TAKO		Port	mil	
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			1 - For State Registrar	State of Ma	ryland		rtment of H		nd Mental F	lygien Reg. N	211111	07917
	Physicia	an .	1. Decedent's Name (First, Middle,						2. Date of Month	D	ay 18 2004	3. Time of Death
	/Medio Examin		Canty Connor 4a. Facility Name (If not institution,	Watson give street and number)			4b. City, Town, o	r Location of		4	County of Deeth	
	Funeral	H	5. Social Security Number		(In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 2		Birth Day, Year	10ntgor	ncru plece (State or Foreign intry)
<u>Bu</u>	Director		None Usual Residence of Decedent	1 ☑ M 2 □ F	0	Yrs.	0 0	1	14 Feb.		004 Mar	yland
	taryland show	ō	10a. State 10b. County		10c. City, T							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith the A or 28e-i	Director	Maryland Mont 10e. Street and Number	gomery	21	iver	Spring 10f. Zip Code			10g. C	itizen of What Cou	intry?
	s 23s	eral [3535 Sheffield				20904	-	in? (Specify Vee or	No-	USA. 14. Rece - Ameri	ican Indian
036	72 hours after death with the Maryland Insturet, or Hems 23s or 28e-1 show disal Esaminet mest te notified at	by Funeral	11. Marital Status 1 XNever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:			Yas Decedent of P Yes, specify Cub ☐ Yes 2 No		in? (Specify Yes or Puerto Rican, etc.)	140-	Black, White	, etc.
Baltimore, Maryland 21215-0036	permit. Fages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "naturat", or itams 23s or 28e-1 show mining the injury or other traumatic event, the Medical Examinet must be notified at once.	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5-		(Give	ent's Usual Occup kind of work done OO NOT use retire	during most	of working		Kind of Business/Ir	ndustry
d 21	Hygiel Hygiel Stherti	S	17. Father's Name (First, Middle, L	ast)			N/A	18. Mother	's Name (First, Mid		N/A n Sumame)	
ylan	Mental Mental arked o	To Be	Timothy E. Wa	tson					gela M. M			
Mar	d 2 sho		19a. Informant's Name/Relationsh Angela M. Minor						or Rural Route Nu.			
more,	Fages 1 an ent of Heal nt: If Item 2 ry or other		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 4 □ Donation 5 □ Other (Sp	3 □Removal from State	20b. Plac	e of Disponetery, cren	sition (Name of natory or other pla fram		Date ebruary 20 2004	20c. t	Location - City or T	
Balti	Dermit. I Departm Importar any inju		21. Signature of Funeral Service L			remat Fr 50	. Name and Addre	ess of Facility Colling Sity B	,			g, MD 20901
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8760,	death certificate be executed as eatending physicien and dior use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Extra Due to (or as a Due to (or as a d.	consequer	, ge	no Bur	7-2	eight i	veor s)	icite	
Box 6	ne death certif the attending thed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel de	eath 3	Ectopic pregnanc	у			23d. Date of delin Month	very Day Year
ds, P.O.	Se Go	þ	Part II. Other significant condition	ns contributing to death bu	ıt not resulti	ng in the ur	nderlying cause gr	ven in Part I.	1		-	the cause of death?
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of	ling Phys	tlon: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending investig	28a. Date of Injur (Month, Day		Outpatien Bb. Time of Injury	28c. Inju Wo	The state of the			6 □Other (Specury occurred	ify)
Division	at or Attending s after death. I Director: After id in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 200 Place of Init	iry - At home :. (Specify)	e, larm, str	eet, factory, office			n (Street a Town, Sta	and Number or Rui te)	al Route Number,
	To the Hospital or I within 24 hours after To the Funerel Dire completely filled in b	edical (29a. Certifier	Physicien: To the best of xaminer: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the treestigation, in my	me, date and opinion, deat	d place, and due to h occurred at the tir	the cause(ne, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 3 To the comple	Me	29b. Signature and title of certifier	0 '	100.		29c. Licen:		270		ate signed (Month	
)	V		Dhares a	Kuruar	-		DO!	167		2	118101	-
-			Dr. Sharon	Kiernan	1500	OF	orest (Glen	Road	Silv	ier Spr	ing,MD20910
	Sta Regist		31. Date liled (Month, Day, Year) FEB 2 3	2004 32. Registra	ar's Signatur	e Ag	Spark	2			•	J'

		State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death		giene Reg. No. 20	04 07918
Physicia		1. Decedent's Name (First, Middle, Last) Rozalia WEINBERGER	2. Date of Dea Month		3. Time of Death 004 4:30 A M
/Medic Examin		4a. Facility Name (If not institution, give street and number) 1121 University Blvd. West, #302 4b. City, Town, or Location of Death Silver Spring		4c. County Montgo	of Deeth
Funeral Director			8. Date of Birt (Month, Da Sept.9,	y, Year)	9. Birthplace (State or Foreign Country) Czechoslovaki
Maryland f show	tor	Usual Residence of Decedent			10d. Inside City Limits 1 ☐ Yes 2 ☒No
death with the Maryland ms 23s or 28s-f show froust be notified at	I Director	10e. Street and Number 1121 University Blvd. West # 302 10f. Zip Code 20902		10g. Citizen of W	
72 hours after death natural, or items 2 olcal Examiner faul	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Marned 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race Blac Specify	e - American tridian, k, White, etc. :: White
be filed within 72 hours after death with the Marylan lat Hygiene. I at Hygiene. d other than "natural", or itams 23s or 28s-f show avent, the Medical Examiner coust be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work) (life. DO NOT use retired) Homemaker	ing	16b. Kind of Bu	siness/Industry Home
uld be filed fentat Hygi rked other tic avent, I	To Be Co	17. Father's Name (First, Middle, Last) Yitzhak Weiss Malvina	Merme	Maiden Sumam 1stein	ie)
es 1 and 2 should be of Health and Mental filem 27 is marked rother traumatic av		19a. Informant's Name/Relationship (<i>Type, Print</i>) Edith Bayme / daughter 19b. Mailing Address (Street and Number or Rural 3720 Independence Ave.	, Bronx	, NY 102	463
Pag In In In In In In In In In In In In In I		1 Donation 5 Other (Specify) 1 Donation 5 Other (Specify) 1 Donation 5 Other (Specify) 1 Donation 5 Other (Specify) 1 Donation 5 Other (Specify)		Boston	,
permit. Pag Department important: any injury o		21. Signatore of Furnal Solice Licensee 22. Name and Address of Facility Tor 254 Carroll St., N 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	.W. Was	hington	
ate be executed // Medical // Examiner // Italian and // Italian a	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, is along to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Lyper of the consequence of the cons	ardion	ny opati	Interval Between Onset and Death
The law requires that the death certific the has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Dat Mor	e of delivery nth Day Year
quires that the de n signed by the a uld be detached f	by	Part It. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	~	ribute to the cause of death? 3 Probably 4 Unknown
The law require	Completed		24a. Was autor perio 1 \(\triangle Yes	osy ormod# c	Were autopsy findings available prior to completion of cause of death?
To the Hospital or Attending Physician: The within 24 hours after death. onthin 24 hours after death. completely filled in by the funeral director, page	ation: To Be		me 5 Nesi	one) dence 6 Other	
al or Attendii s after death. il Director: A sd in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	Street and Numb wn, State)	er or Rural Route Number,
To the Hospital or A within 24 hours affer To the Funeral Dire completely filled in b	edical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and manner stated.		date and place,	and due to the cause(s)
To with	2	29b. Signature and title of certifier The state of certifier 1		Febr	d (Month, Day, Year) HUNY 22, 2004 MD 20855
·		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atrical Towns Ko Nay, 6/2 31. Date filed (Month, Day, Year) 32. Registrar's Signature	, Roc;	Kville,	MD 20856
St Regist	ate trar	FFB 23 2004 Some & Sparks			

	1	For State Registrar Decedent's Name (First, Middle, La	State of Mary	Cei	tificate of	Death	Reg. N	2001	
Physiciar /Medica Examine	n il	Leon Ralph Wesl a. Facility Name (If not institution, give	еу		4b. City, Town, or	Location of Death	Month D February	Pay Year 16, 2004 Ic. County of Dea	4 8:00 A
uneral				yrs. last birthday)	If Under 1 Year Months Days	ethesda If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	ir) Co	thplace (State or Fore cuntry)
rector	-	577-10-4181 Journal Residence of Decedent Oa. State 10b. County		c. City, Town or Lo	cation		Apr 7, 19	917 W	ashington,
28a-f sho	ector	Maryland Montg	omery	Silver	Spring		10g. (Citizen of What Co	1 ☐ Yes 2/☐ ountry?
od other than "natural", or items 23a or 28a-i show event, it in Medical Examiner mant he notified at	rai Di	531 Rando1ph Rd 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Apt. 138A 12. Was Decadent Ever Armed Forces? 1 107 Yes 2 □ No If Yes, Give Year or Dates:	_	2090 Was Decedent of H f Yes, specify Cuba	4 ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - Ame Black, Whit	te, etc.
Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Education	(Give	DO NOT use retired	during most of work.		Kind of Business	,
ked other th	To Be Con	12 7. Father's Name (First, Middle, Las Frank Wesley	it)	Pol	Liceman_		e (First, Middle, Maid	Law Enfo	orcement
Important: If item 27 is marked any injury grother treumatic evenue.	2	19a. Informant's Name/Relationship Frank L. Wesley 20a. Method of Disposition 1X Burial 2 Cremation 3 (4 Donation 5 Other (Spec	/Son □Removal from State	1152 20b. Place of Dispo cemetery, crea Fort Line	25 Scotts sistion (Name of matory or other place coln Ceme 2. Name and Addre	bury Ter, tery Feb_ ss of Facility Hin	Germantov Cate 200. 19, 2004 es-Rinalda Ave, Silv	n, MD 20 Location City or Brentwood Funeral	Town, State
sician and edical iminer,	ical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	y one cause on each line. Rupto	ured Aori onsequence of): riosclero	er the mode of dyir	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Deat 2 weeks
by the attending phy tached for use as th		tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	∃Ectopic pregnancy ∃ Other <i>(specify)</i> _	,		23d. Date of de Month	livery Day Year
gue d	ر ک	Part II. Other significant conditions Hypertensive He	-	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobacc		o the cause of death robably 4 DUnkn
certificate has been si irector, page 2 should I	Completed	Chronic Obstruc	tive Pulmona	ry Diseas	se		24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings avai completion of cause s 2 □ No
After this funeral d	To B	25. Was case referred to medical examiner? 1	be -		f 28c. Injur Wor M 1 🗆	er: 4 Nursing Ho	h (Check only one) me 5 Residence 28d. Describe how in	jury occurred	
aral Direct	edical Certific	4 Homicide determine	building, etc. (Specify) ny knowledge, deal	h occurred at the til	ne, date and place,	28f. Location (Street City or Town, St	ate) (s) and manner a	s stated.
4 5	ğ	(Check only 2 Medicel Exa	aminer: On the basis of ex and manner stated			e number		Date signed (Mon	
To the Funeral Director: completely filled in by the	¥	29b. Signature and title of sertifier			29C, LICONS	a manneon			ili, Day, Itali

State of Maryland / Department of Health and Mental Hygiene 2004 07920 Certificate of Death Reg. No 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** February 16, 3:10 a M Whitty 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sacred Heart Home Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **Funeral** Months 1 ☐ M 21X F 89 Director 272-10-4547 June 10, 1914 Pennsylvania Usual Residence of Decedent Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or 28a-f ehow Examiner must be notified at 11 Yes 2 No Directo Maryland Prince George's College Park the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6100 Westchester Park Drive, #1203 20740 U.S.A. Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 le marked other than "natural", or ite Lry or othar traumatic event, the Medical Examination. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify 9 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vishnowsky George Kuzmiskey Anna Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20740 19a. Informant's Name/Relationship (Type, Print) Marie S. Sollod - Niece 6100 Westchester Park Drive, #1203, College Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/20/2004 Silver Spring, MD Gate of Heaven 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signatury of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4739 Baltimore Avenue, Hyattsville, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate ba executed Volume Depletion and resulting in death) Last Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical Failure to Thrive use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗓 No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Hypertensive Cardiovascular Disease Congestive Heart Failure; Progressive Cognitive 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1 ☐ Yes Decline 2XX No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☑ No 3□ DOA Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death.

Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number an an D0051122 February 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Esmerando Juanitez, MD 1160 Varnum Street NW, Washington, DC 20017 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year RUBY MAE WALLACE **Physician** Februar 16 2004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Lanham Prince George's Doctors Community Hospital 8. Date of Birth
July 12, 1923 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min Georgia 1 M 2 X F 261-38-8597 80 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f ehov saical Evaniner must be notified at Fort Pierce 1 XYes 2 No FLSt. Lucia Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 34950 904 North 21st Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: Black Completed by 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical than Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Private Industry 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked Jonas Daniels Callie Kirkland permit. Pages 1 and 2 shoul Department of Health and Me Important: It item 27 is mark any injury or other traumati 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Haynes/Daughter 6001 Elmendorf Drive, Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/28/2004 Fort Pierce, FL Pine Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. Signature of Funeral Service Licensee 4111 Pernsylvania Avenue, Suitland, ND 20746 23 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** ancheal /Medical Due to (or as a consequence of) **Examiner** Je Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit je Electroly Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician ifertension Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 3 ☐ Probably 4 ☐Unknown 2 🗆 No 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Liners e2- se has autopsy performed? page Mynothyroid: 25. Was cas referred to medical certificate 2 No 1 Yes Attending Physician: director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To his 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? uneral 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: A filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide after within 24 hours a 1 (Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier ress of person who completed cause of death (Item 23a) (Type, Print) Cheverly, nd, 20785 andover 6005 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 2 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 07922 For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Eliza White Feb<u>ruary</u> 17, 2004 1:40 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) Examiner Manor Care of Upper Marlboro Upper Marlboro Prince George If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F Yrs 93 1910 South Carolina 578-52-3764 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or thems 23s or 28a-1 show any injury or other traumatic event, the Medical Exemines. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No Director Maryland Prince George Upper Marlboro 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12800 Princeleigh Street 20774 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married ☐Yes 27 No f Yes, Give 1 ☐ Yes 2 ☐ No Specify Specify: by 3 □ Widowed 4 □ Divorced Year or Dates B1ack Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Perry Wilson Adelaide McFadden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wilbur White/Son 12800 Princeleigh St., Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 🛱 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2-21-2004 Frentwood, Maryland 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Septice Licensile 13401 Bladensburg Rd., Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition **Physician** Adult Failure to Thrive resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Alzheimer's The law requires that the death certificate be executed burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2X No 9 Unknown 9 Unknown signed by deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Yes 2 No 3 Probably 4 Nunknown Completed been 24a. Was an autopsy performed? 1 Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 🗌 Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 X No 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending Injury 1 XNatural M 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the Director 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur d title of certifier 1)12261 February 18, 2004 30. Name and address of person and completed cause of death (Item 23a) (Type, Print) 9500 Annapolis Rd., #A-4, Lanham, MD 20706 Richard J. Feldman, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 9 2004 Registrar

			For State Registrar	State of Marylan	id / Depa <i>Cei</i>	artment of H	lealth and I Death	Mental Hygid	ene 2004	07923
T			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yeer	3. Time of Death
	Physici /Medic		David	Willi	ams			February	14, 2004	9:26 P M
	Examin		4a. Fecility Name (If not institution, give s				r Location of Death	1	4c. County of Deeth	_
			Southern Marylan		to a bilated and	Clint If Under 1 Year		8. Date of Birth	Prince Ge	eorge's
	Funeral Director		5. Social Security Number 251-76-8278 6. Sec. 251	7. Age (In yrs. 59	Yrs.	Months Days	Hours Min.	(Month, Dey,)	(eer) Cou	th Carolina
	ס		Usuel Residence of Decedent							10d Inside City Limite
	anylan show	_	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	ecto	MD Prince Geo	orge's	Brandy	10f. Zip Code		100	. Citizen of What Cou	A
	a or	2	THE STATE OF THE S							,
	eath	era	6802 Burch Hill R	12. Was Decedent Ever in U	l.S. 13.	20613 Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	U.S.A. 14. Race - Amer	
20	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hyglene. If item 27 is merked other than "naturel", or items 23a or 28a-f show or other traumatic avent, it a Medical Examinar must be notified at	Completed by Funeral Director	1 □ Never Ma <i>n</i> ied 2 🔀 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ★Yes 2 No Ar If Yes, Give Year or Dates:	mv	f Yes, specify Cuba 1 ☐ Yes 24 No	Specify:	o Rican, etc.)	Specify: B	, etc. Lack
21215-0030	2 hou	ted	15. Decedent's Edu (Specify only highest grade	cation		dent's Usual Occup			6b. Kind of Business/I	ndustry
7	within 7 ene. than "r	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)		Carromana	-
2	filed w Hygier Ather th	ဝိ	17. Father's Name (First, Middle, Last)	2 yrs	Agen	T	18 Mother's Nar	ne (First, Middle, Ma	Government	
Maryland	d be fi	Be c		liams			Bernice		Alston	
2	should nd Men marke umaric	ပ	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State, Z	ip Code)
	alth a		Catherine V	Villiams/Wife	6802	Burch H	ill Rd. 1	Brandywin	e, Marylan	d 20613
ē,	of Health of Health item 27 I		20a, Method of Disposition		Place of Dispo	sition (Name of matory or other plac	ce)	Date 20	Oc. Location - City or 1	own, Stete
altimore,	Pages nent of I		12☐ Burial 2 ☐ Cremation 3 ☐ F *4 ☐ Donation 5 ☐ Other (Specify)	Ma:	ryland	Veteran'	s 2-2	4-2004 C	heltenham,	Maryland
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	1.all		2. Name and Addre	· J	. B. Jenk d Landove:	ins Funera r, Marylan	1 Home d 20785
f			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the dea ne cause on each line.	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arres	ot,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	CA O	PLD:	STRATE				Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
		<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Dies to (or as a nonser	ouanna offi-					
	red nsit	nfn	Cause (Disease or Injury		,					
<u>,</u>	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	cai		d						
9	leath certificate b attending physic I for use as the b	ed	IF FEMALE:							
Box	ath ce ttendi or use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3	Ectopic pregnancy	1		23d. Date of deli Month	very Day Year
		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of ∈ 9 Unknown	death bl	Other (specify) _				
_	that the dended by the detached		Part II. Other significant conditions co.	ntributing to death but not re	sulting in the u	inderlying cause giv	ren in Part I.	23e. Did toba	icco use contribute to	the cause of death?
g	quires n sign ald be	d by						1 □ Yes	2 □ No 3 □ Pro	bably 4 Unknown
Vital Records,	law requires that the as been signed by th 2 should be detache	Completed						24a. Was an	24b. Were au	opsy findings available
Ž Ž	e - e	E O						autopsy perform 1 Yes 2	ed? death? XNo 1 ☐ Yes	ompletion of cause of 2000 No.
<u>ra</u>	ien: Th rificate	0	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one		
o	Physicien: this certific ral director,	To B	1 Yes 2 No	Hospital: 1 ☐ Inpatient 27	ER/Outpatie				ce 6 Other (Spec	eify)
			27. Manner of Death 1 △ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	Wor		28d. Describe how	v injury occurred	
<u>s</u>	ten leath tor:	cati	2 Accident investigation 3 Suicide 6 Could not be	OR Disease laines As h			Yes 2 □ No	28f Location (Str	eet and Number or Ru	m I Pouto Number
Division	E Pite	Certification:	4 Homicide determined	28e. Place of Injury - At It building, etc. (Special Control of the Control of th	ify)	reet, factory, office		City or Town,		al Addie Namber,
_	spita ours veral	edical Ce		rsician: To the best of my kn iner: On the basis of examin and manner stated.						
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manifer stated.		29c. Licens	se number	29	d. Date signed (Month	, Day, Year)
}	F \$ 1500			Ko W	\sim	1741	5 80		1/16/20	204
9	10		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type,		- 00		10/00	
			Scott Kelso				inton, Ma	ryland 20	735	
ŧ.		ate	31. Date filed (Month, Day, Year) FFR 1 8 2004	32. Registrar's Sign	ature	6,				
	Regist	rar	FEB 1 8 2004	JUDICIAN JO	145.00					

DHMH 17 Rev 1/2001

to ultiams, David

			For State Registrar	State o	of Marylan	•	irtment of F tificate of		Mental Hy	giene Reg. No. 200	4 07924
40	Physici		1. Decedent's Name (First, Midd.) Jacqueline M		re - Wil	liams			2. Date of Dea Month FEBIL UP	Day Yea	
	/Medic Examin	-	4a. Facility Name (If not institution	n, give street and nu Hospital	mber)		4b. City, Town, o	r Location of Dea Inham		4c. County of De Prince G	
	Funeral Director		5. Social Security Number 214-98-9249	6. Sex 1 ☐ M 2 🏋 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	Birthplace (State or Foreign Country) SC
	Maryland f show	or	Usuaf Residence of Decedent 10a. State 10b. County			, Town or Lo					10d. fnside City Limits 1 X Yes 2 No
	desth with the Maryland ms 23e or 28e-f show rmust be rollfled at	Director	10e. Street and Number	George's		vattsv:	10f. Zip Code	1707		10g. Citizen of What	Country?
36	be filed within 72 hours after desth with the Marylan tal Hygiene. Id other than "natural", or Itams 23a or 28a-f show event. The Medical Exuminac must be collited at	by Funeral	6805 Eldridge 11. Maritaf Status 1X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorces	rried Armed F	2 XNo		Vas Decedent of H f Yes, specify Cubi	0784 lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	- 14. Race - A Black, W	
Maryland 21215-0036	within 72 hour ene. than "natural' he Medical Ex	Completed b	15. Deceder	nt's Education est grade completed,		(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking	16b. Kind of Busine	,
ב פר	e filed with al Hygiene. other thai	Be Cor	12th 17. Father's Name (First, Middle,	Last)			Book Ke		rme (First, Middle,	Pv Maiden Sumame)	t
ırylar	2 should be filed vand Mental Hygie is marked other raumatic event. L	To	Sam Whitmin 19a. Informant's Name/Relation:			19b. Mailir	ng Address (Street		a Allen-C	Gray er, City or Town, State	e, Zip Code)
	and 2 s lealth ar m 27 is her trau		Robert C. Willi			-	Eldridge	St. H	yattsvill Date	Le, MD 207	
altimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke eny injury or other traumatic angon.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3)		State	emetery, crer	e Cremato		2/18/04	Riverdal	2515
Balti	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service	Licensee	all		. Name and Addre		.B. Jenki Landov	ins Funera ver MD 2	1 Home 0785
> .	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis firmediate Cause (Finaf disease or condition resulting in death)	t only one cause on	each line.	eumo	,	ng, such as cardia	ac or respiratory ai	rrest,	Approximate Interval Between Onset and Death
7	Examiner	Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		(or as a consequence of the cons	DC	Agenired	Imm	odeh'cu	uy Spolm	
8760,	te be exe ysician ar ne burial-t	dical Ex	resulting in death) Last	d.	(or as a consequ	uence of):					
O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregna birth 2 Tetal nant at time of de nown	death 3	Ectopic pregnancy	/		23d. Date of Month	delivery Day Year
s, P.	w requires that the de been signed by the s should be detached t	þ	Part fl. Other significant condit	ions contributing to	death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	1 /	e to the cause of death? Probably 4 □Unknown
Division of Vital Record		Completed							24a. Was autor perio 1 □ Yes	osy prior death	autopsy findings available to completion of cause of ?? /es 2 \(\text{No} \)
Vita	ysician: Th iis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:>	Hopatient 2□	ER/Outpatier	at 3□ DOA Oth	000	eath (Check only only only only only only only only	one) dence 6⊟Other(S	pecify)
sion of	ig Pt ter th	Certification: T	E - Accident	tigation	of fnjury nth, Day Year)	28b. Time o Injury	M 1	yat k? Yes 2 □ No		how injury occurred	
Dİ <u>X</u>	el or Attendin s after death. al Director; Af ed in by the fur	Certifle	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 28e. Plac	e of Injury - At ho ding, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (: City or Tox	Street and Number or wn, State)	Rural Route Number,
	e Hospitel 124 hours a e Funeral L letely filled	edical		I Examiner: On the						cause(s) and manner date and place, and o	
	To the within 2 To the complet	Me	29b. Signature and title of certifi	er	,		29c. Licens			29d. Date signed (Mo	,
0	(1)		30. Name and address of person	n who completed car	use of death (Item	1 23a) (Type,	1) 5 Print)	5/18		4/13	104
_	(0)		THOMAS HAD 31. Date filed (Month, Day, Yea.	USSON,	M. D. 5 Registrar's Signa	25 MA	11ND STREE	T 54/1	€ 351	LAIREL, M	113 20707
	Sta Regist	ate rar	FEB 18 2		w &	Spar	K)				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev Vear Physician 2:40 P.M. EVELYN WRIGHT February 1, 2004 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner PRINCE GEORGE'S GLADYS SPELLMAN SPECIALTY HOSPITAL HYATTSVILLE If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Funeral Days Months Hours 1 ☐ M 2 🛣 F 65 Yrs Director Feb.14, 1938 Dinwiddie, VA. 223-46-2345 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural" ---- ery injury or other traumatic excent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 □ No Petersburg | 10f. Zip Code Directo Virginia 10e Street and Number 10g. Citizen of Whet Country? 23803 U.S.A. Funeral 107 Spring Street 11 Maritel Status 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 XNo Specify: Be Completed by Specify: 3 Widowed 4 □ Divorced BLACK 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Private Families** Domestic 12th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Winfield L. Adam 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Spring Street Petersburg, Va. 23803 Della Winfield/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/7/04 Petersburg, Va. Wilkerson Mem.Cemetery 21. Signature of Hungral Service Licensee 22. Name and Address of Facility Frazier's Funeral Home, Inc. 389 Rhode Island Ave., N.W. Wash.,DC 20001 23a. Part1. Enter the disease, of conditications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical a Respiratory Failure Examiner Due to (or as a consequence of): Examiner b. Chronic Obstructive Pulmonary Disease Hospital or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? XING 1 □ Yes 2 No 1L Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this : After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation erei Director: Af death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier сотрівтел (Check only one) 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Dev. Year) Feb.10, 2004 D0026024 30. Name end andress of person who completed cause of deeth (Item 23e) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

State

LESTER MILES, MD 31. Date filed (Month, Day, Year)

FEB 1 8 2004

Registrar's Signature

6430 Landover Road Suite F Landover, Md. 20785

		-	For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of F rtificate of	lealth and M Death		Reg. No.	00	
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last) Alneda L. I	Woods				2. Date of De. Month Februar	Day 12		3. Time of Death
7	Examin	- /	4a. Facility Name (If not institution, give s				r Location of Death		4c. Coun	,	
			Doctors Community 5. Social Security Number 6. Sex		last birthday)	Lanham If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			orges
	Funeral Director			7. Age (iii yis	Ven	Months Days	Hours Min.	(Month, Da May 20	y, Year)	Ray	thplace (State or Foreign buntry) City, Ga.
	/land		10a. State 10b. County		ity, Town or Lo						10d. Inside City Limits
	Mary a-f sh	to	Maryland Prince Geo	orges	itchel	lville					1 XYes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What C	ountry?
	23a	ai	14608 Man O War Dr			20721			United		
215-0036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show ant, Ite Maylical Ext. of the Collins at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Ra Bl: Spec	ack, Whi	erican Indian, te, etc. Lack
Ş	72 ho	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of	Business	/Industry
7	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	,,,,	U.S. (Gove	rnment
7	ygien ygien ner th	ပ်		4	Cor	ntracting		- /5: Adid-II-	Maidan Com		
Maryland	be fill Hatal Had off	Be	17. Father's Name (First, Middle, Last) David Jenrette				18. Mother's Name Maggie		Maiden Suma	ime)	
$\frac{3}{2}$	d Mer nark	٩	19a. Informant's Name/Relationship (Ty)	ne Print)	10b Mailie	na Address /Street	and Number or Rura		er City or Tour	n State	Zin Code)
<u>B</u>	d 2 si th an t7 is r traul						ar Dr. Mi				20721
อ์	Heal Heal tem 2		Alvin L. Woods / 20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date	20c. Location		
<u></u>	ages ent of nt: ff i		1 Donation 5 Other (Specify)	emoval from State	-	matory`or other plac Iemorial		21,2004	Landov	ver,	Md.
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ite Mode.		21. Signature of Funeral Service License	e Natost	27	Name and Addre	ss of Facility Pope boro Pike	Funeral /forest	Homes	Md.	20747
E	N .		23a. Part1. Enter the disease, or compli	cations that caused the dea	th. Do not ent	er the mode of dyin	ng, such as cardiac o	or respiratory ar	rest,		Approximate
	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	nstru quence of):	ctive Lo	IN Dise	ase			Interval Between Onset and Death
		-	Sequentially list conditions,	Due to (or as a conse	quence of):					_	MONTH
	xecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last		100	cilare					IMOUTH 2 MOUTH: 2 mouths
58760,	ificate be executed g physician and as the burial-transit	edicai E		Due (or as a conse	il Iv	faremon)				2 months
P.O. Box 6	Attending Physician: The law requires that the death certificaeth. cotor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3[Ectopic pregnancy Other (specify)	1	-		ate of de lonth	livery Day Year
	signed by	by	Part II. Other significant conditions con		sulting in the u	nderlying cause giv	en in Part I.		obacco use con		o the cause of death?
Ö	w requir been si should	ete	1100001					24a, Was	an 24h	Were a	utopsy findings available
Ä	Physician: The lav this certificate has al director, page 2	Completed						autor perfo	med?	prior to death?	completion of cause of
ta	an: T tificat tor, p	0	25. Was case referred to medical				26. Place of Death	1 ☐ Yes	No No	1 1 103	24/110
\leq	ysici ils cer direc	To B	examine N	lospita // Inpatient 2[] ER/Outpatier	nt 3 DOA Oth				ther (Spe	ocify)
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		2) Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ⊡No	28d. Describe I	now injury occu	irred	
Divis	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		reet, factory, office		28f. Location (S City or Tox		nber or R	ural Route Number,
	ne Hospital n 24 hours a ne Funeral pletely filled	edical		sician: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occurr	ed at the time,	date and place	, and due	e to the cause(s)
	To the within 2 To the complete	M	29b. Signature and title of certifier	mpleted cause of death (Ite		29c. Licens	7603		29d. Date sign	ed (Moni	th, Day, Year)
R	(5)		30. Name and address of person who a	impleted cause of death (Ite	om 23a) (Type,	Print) 1+challus	le Rd	3216	Bow	ù.	110 20116
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 7 2004	2. Registrar's Sign	doc	le de la company				estration of the	
			2		-						

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

1 7 2004

		1 - For State Registrar	State of M	aryland	l / Depa <i>Cer</i>	artmen tificat	t of Heal e of Dea	th and		iene 2	00	4 0792
Physici /Medic		1. Decedent's Name (First, Middle, L David L. Wa	rd						2. Date of Deat Month February	Dey 10	Year 2004	
Examin	er	4a. Facility Name (If not institution, g Suburban Hosp				4b. City,	Town, or Loca Beth	esda		4c. Cou	nty of Deer Mont	gomery
Funeral Director		100-12-1300	Sex 1 M 2 F 7. Ag	ge (In yrs. Ia 85	st birthday) Yrs.	If Under Months		nder 24 Hrs urs Min			Co	thplace (State or Fore buntry) nsylvania
within 72 hours after death with the Maryland ene.	ector	Usual Residence of Decedent	tgomery	10c. City,	Town or Lo			er Sp	ring	Og. Citizen	-1167 C-	10d. Inside City Lim 1 □XYes 2 □ 1
H With 1	Dir.	8502 - 16th	St., #314			10f. Zip		0910	, ,			States
o within 72 flours arien beauth with the many and joine. Than "natural", or items 23a or 28a-f show the Mcdical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ∰Divorced	12. Was Decedent Armed Forces? 1X Yes 2 If Yes, Give Year or Dates:	,		Vas Dece Yes, spe		ic Origin? (xican, Pue ecify:	Specify Yes or No- rto Rican, etc.)	14. F		erican Indian, e, etc.
within 72 ho ene. than *natur he Medical	Completed by	15. Decedent's (Specify only highest g	completed) College (1-4or		(Give life. L	kind of wo DO NOT u	al Occupation rk done during se retired)		orking	16b. Kind of	Business	/Industry
be filed ital Hygi of other event, I	To Be Cor	17. Father's Name (First, Middle, Las Harry Ward	st)		Music	ian/C	ompose 18. M		ductor me (First, Middle, M Gertrude	taiden Sum	ame)	ployed
other traumatic		19a. Informant's Name/Relationship Enid B. Ward				_			dural Route Number, 314, Silve			
Department of He Important: If item any injury or other once.		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec		Cel	nce of Dispo metery, crem tico	natory or c	ther place)	m, 2/:	Date 2 23/2004			Town, State
Departr Importa any inje		21. Signature of Fiuneral Service Lice	T bourt	II	22				Stewart Fi ., N.E. Wa	ıneral	l Hom	
ate has been signed by the attending physician and control of cont	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as d.	a conseque	ence of):							Onset and Death Months
by the attending phatached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal c	death 3	Ectopic pi					Date of del	ivery Day Year
been signed b should be deta	by	Part II. Other significant conditions Metastatic Prostate		out not result	ting in the ur	iderlying c	ause given in F	Part I.		acco use co s 2 □ No		the cause of death?
	e Completed	Pulmonary Hyper Acute Renal Fai 25. Was case referred to medical					2 2 2	Place of Do	24a. Was ar autopsy perform 1 Yes 2	ed?		itopsy findings availa completion of cause 2 No
this ral dii	on: To B	examiner? 1 Yes 2 X No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		R/Outpatien 28b. Time of Injury		The second second		Home 5 Resider	nce 6 🗆 C		cify)
within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification;	2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inj		ne, farm, stre	M et, factory	1 ☐ Yes	2 🗆 No	28f. Location (Str City or Town		mber or Ru	ıral Route Number,
within 24 hours after To the Funeral Dir completely filled in	dical	29a. Certifier (Check only one) Certifying F 2 Medical Example 1	Physician: To the best aminer: On the basis o and manner st	of examination	ledge, death on and/or inv	occurred restigation	at the time, da , in my opinion	te and plac , death occ	e, and due to the ca urred at the time, da	use(s) and te and plac	manner as e, and due	stated. to the cause(s)
within 2 To the	Me	29b. Signature and title of certifier					:. License num					h, Day, Year)
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B.K.S LEONA MILLS WOODSON

	1 - State Unpend Item#23 1. Decedent's Name (First, Middle, I		3,J/JI/(H Q	rtificate of	Death	2. Date of D	Reg. No.		3. Time of Death
Physician		ona Hoover M	ills-Wood	lson		Month FEB.	27. 20	Year	2325 P
/Medical Examiner	4a. Fecility Name (If not institution, g	nive street and number)			or Location of Death			ty of Death	
}# ₁ •	PRINCE GEORGES			CHEVERI					ORGES
Funeral Director	579-72-1414		n yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, C Novemb	irth 1952 Day, Year, Der 12,	9. Birth Cou Wash	place (State or For intry) nington,D
*	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation					10d. Inside City Lir
r 28e-f show crafffind at frector	District of Colu	ımbia	Washi	ington					1 X Yes 2□
be notified Director	10e. Street and Number	1110 24	Wash	10f. Zip Code			10g. Citizen of	What Cou	intry?
° # 0	3914 - 10th Str	eet, N. E.		2001	.7		Unite	ed St	ates
Examiner coust Examiner coust by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub	lispanic Origin? (S _I an, Mexican, Puert Specity:	pecify Yes or N Rican, etc.)	o- 14. Ra Bl Spec	ack, White	ican Indian, , etc. ack
natural lical Ex eted b	15. Decedent's (Specify only highest of	Education prade completed)	16a. Dece	dent's Usual Occup	pation during most of word d)	kina	16b. Kind of		
ygiene. ner than "naturi it, the Midical I	Elementary/Secondary (0-12)	College (1-4or 5+)	1						of Washi Institut
Col	12th grade 17. Father's Name (First, Middle, La	ct)	Commu	inity Sup	port Cour				Institut
n and Mental Hygier Is marked other It reumatic event, the To Be Col	Samuel Mills				Albert			_	
th and Men 7 is marke treumatic	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street	and Number or Ru			unkn	
	Charles Steve W								
t Heg	20a. Method of Disposition		20b. Place of Dispo			Date	20c Location		
Department of Importent: if it is any injury or concept.	1 ♣ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Special Control	oify)	Maryland	National	Memoria]		Laure1	_	,
Depar Impor any ir QUCB.	21. Signature Funeral Service Lic	al Cul		Name and Address. N. Hor 00 Kenne	ess of Facility ton Compa dy Street	ny Mort	ticians, Washingt	Inc.	.c. 20011
W. #	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the ly one cause on each line.	death. Do not ent	er the mode of dyw	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
ysician	Immediate Cause (Final disease or condition	Hypertension	ve Cardiova	scular Dise	ease				Onset and Death
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	Sequentially list conditions,	b. Due to (or as a co	Vana na contra confl.		<u> </u>				
niner	tany, leading to himediate cause. Enter Underlying Cause (Disease or injury	Sue to for as a co	oneeqtientie-oty:						
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igned by be detac by Ph	Part If. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cor	tribute to t	he cause of death
been sig should b						1 🗆	Yes No	3 🗆 Prot	bably 4 Unkno
has ye 2						24a. Was		Were auto	opsy findings availa impletion of cause
certificate has rector, page 2 Be Comp						*Ores	2 No	Yes	2 □ No
	25. Was case referred to medical examiner? 12 Ves 2 □ No	Hospital:	-Menie	t 3 DOA Oth	26. Place of Deal				
5 - I	27. Manner of Death	28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of	1 3 DOA	4 Nuising no		idence 6 Ot		(y)
: After s funer tion:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat		ar) Injury	28c. Injur Wor M 1 🗍	k? Yes 2 □No				
24 nours after deam. 8 Funerel Director: Attert etaly filled in by the funera dical Certification:	3 Suicide 6 Could not determine	be 390 Place of Injune	At home, farm, str Specify)	eet, factory, office		28f. Location (City or To	(Street and Num wn, State)	ber or Rura	al Route Number,
ille C	29a. Certifier 1 Certifying (Check only one) 2 X Madical Ex	Physician: To the best of maminer: On the basis of examiner stated	amination and/or inv	occurred at the tir	ne, date and place, pinion, death occur	and due to the	cause(s) and m	anner as s	itated. to the cause(s)
Fun Fun dica		and marinor stated	•	29c. Licens	o number		29d. Date signe	ad (Month	Day Year)
o the Funer ompletely fill	29b. Signature and title of certifier	†		250. LIGHTS	e number				
To the Fun completely Medica		1 16,00 m	\mathcal{N}						
⊆ E		re Uhull M	((Item 23a) (Type	0.0	C.M.E		FEB		, 2004

			1 - For State Registrar	State of Maryla	nd / Depa	artment o	of Hea	alth and		giene Reg. No. 20	04 07930
	Physici /Medio		Decedent's Name (First, Middle, Last) Helen L. Younger						2. Date of Dea Month Feb.	21, 20	3. Time of Death 04 4:30 a M
?	Examin		4a. Fecility Neme (If not institution, give			4b. City, Tov			eath	4c. County	
			Anne Arundel Medi 5. Social Security Number 6. Sex		. lest birthday)	If Under 1 Y	_	olis Under 24 H	trs. 8. Date of Birt		ne Arundel
ľ	Funeral Director		219–20–7078	M 2⊠F 77	Yrs.				Mar. 15	y, Year)	Birthplece (State or Foreign Country) MD
	yland		Usuel Residence of Decedent 10a. State 10b. County		ity, Town or Lo		-	-			10d. Inside City Limits
	the Mar 28a-1s	ector	MD Anne Ar	rundel		10f. Zip Co	rnol	.a 		10g. Citizen of W	1 ☐ Yes 2 ☑ No
	Mith Ba or	i Dir	469 Broadwater Ro	pad		101. 210 00		1012			USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show appringuy or other traumatic event, the Modical Exerting Court could be notified at ance.	by Funeral Director		12. Was Decedent Ever in l Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:	+	Was Deceden If Yes, specify 1 ☐ Yes 2	t of Hispa Cuban, N		(Specify Yes or No- uerlo Rican, etc.)		- American Indian, (, White, etc.
21215-0036	a within 72 ho giene. ir than "natur it e Modical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use r	fone durii etired)	ng most of	i	Kennedy Childre	
land;	buld be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) John C. Younger				18		Name (First, Middle, n M. Robil		9)
Maryland	od 2 should th and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (Ty Janet Temple/Niec						Rural Route Number, Arnold,		
Baltimore,	Pages 1 and 3 nent of Health int: if Item 27 ary or other tri		20a. Method of Disposition 1X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Inmoved from State	Place of Dispo cemetery, cre- edar Hi	matory or othe	r place)	y F	eb. 25,	20c. Location - 0	City or Town, State
Balti	permit. Pag Department Important: I any injury o		21. Signature of Fineral Service License	2/1_	22 E	Name and A Barranc 195 Gov	ddress o	Sons, tchie		erna Par erna Par	k Funeral Home k, MD 21146
	Pnysician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	Bo not en		f dying, s	uch as care			Approximate Interval Between Onset and Death
	Examiner	L	Sequentially list conditions,	Due to (or as a conse							
8760,	The law requires that the death certificate be executed at the been signed by the attending physicien and page 2 should be detached for use as the buriat-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
.O. Box 6	that the death certifice ed by the attending ph detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	Gc. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	tel death 3	□Ectopic pregr □ Other (speci				23d. Date Mon	e of delivery th Day Year
۵.	uires that the signed by to detach	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	inderlying caus	e given i	n Part I.	23e. Did to	/	bute to the cause of death? 3 Probably 4 Unknown
al Records,		Completed							24a. Was autop perfo 1 \(\text{Yes}	med? d	/ere autopsy findings available rior to completion of cause of eath?
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:			Othor		Death (Check only o		
of	ling Physician: After this certification in the control of the co	ion: To	27. Manual of Death	1 patient 2 2 28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury		Injury at Work?		g Home 5 Resid	lence 6 Othe	
Division	the Hospital or Attending I within 24 hours after death. I the Funeral Director: After ompletely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st			2	28f. Location (S City or Ton		or or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exami	sician: To the best of my kr ner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	h occurred at to	he time, my opini	date and pl	ace, and due to the occurred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	Vithin Vithin To the	Me	29b. Signature and the of certifier	1-		29c. L	icense nu	umber		29d. Date signed	(Month, Day, Year)
)			> Visite	rollin mi)	D	384	175	in programme	2/2	1/2004
			Low WE	ompleted cause of death (Ite	IC 18	Print)	1	Ave:	Julie	121 19	mujelli no
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 3 2	32. Registrar's Sign	nature	fork					,

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			Fo.						nd Mental Hy	aiene	3	
			1 - State Registrar				rtificate o			Reg. No	2004	07931
	Physici	an	1. Decedent's Name (First, Middle, Las	•					2. Date of De Month		Y Year	3. Time of Death
>	/Medic	al	Alice Kathleen Zi								5, 2004	1:19 p™
	Examin	er	4a. Facility Name (If not institution, give Northampton Manor		Home		Freder	or Location of I	Jeath		. County of Deat Frederic	
	Funeral		5. Social Security Number 6. Se	9x 7. Ag	e (in yrs. last	birthday)	If Under 1 Yea	r If Under 24				hplace (State or Foreign
ì	Director		215-10-/238	□M 2031F	89	Yrs.	Months Day	s Hours	Min. (Month, Da Dec. 11	,191	4 Mar	yland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or La	cation					10d. Inside City Limits
	Maryl -f aho	to	Maryland Frederic	k	Walke	ersvi	.11e					t x tes 2 □ No
	or 28a	Director	10e. Street and Number		-		10f. Zip Code			10g. Cit	izen of What Co	untry?
	23a c	ralD	8813 Fountain Roc	k Road			2179	3			USA	
	er dez Items	Funeral	11. Marital Status	12. Was Decedent I		13.	Was Decedent of If Yes, specify Cu	Hispanic Origin Iban, Mexican, F	n? (Sp <i>ec</i> ify Yes or No Puerto Rican, etc.))-	 14. Race - Ame Black, White 	
036	urs aft		1 ☐ Never Married 2 ☐ Married 3 反 Widowed 4 ☐ Divorced	1 ☐ Yes 2 反↑ If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 ☑ N	o Specify:			Specity: Wh	ite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than 'natural', or tems 23a or 28a-f ahow int, the McCircl Exantrer court be multified at	Completed by	15. Decedent's Ed (Specify only highest gra		1	6a. Deced	dent's Usual Occ	upation	f working	16b. K	ind of Business/	Industry
2	hen "	mple	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of work don DO NOT use retii nemaker	red)	Working		Own Ho	me
	filed v Hygie ther t		17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	Maiden		
au	ld be ental ked o	To Be	Daniel Ford Hedg	es					et Sweadne			
Maryland	shou and M s mar	_	19a. Informant's Name/Relationship (7		1	19b. Mailir	ng Address (Stree		or Rural Route Numb		or Town, State, Z	(ip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other than "natural" or flems 23e or 28e-1 ahow any injury or other traumatic event, the Marylan Examinet chart by notified at 000s.		Doris Flanigan/ Da	ughter			The second second second	Ridge Ro	oad, Rocky			
Baltimore,	ges 1 it of H if iter or oth		20a. Method of Disposition 1√□ Burial 2 □ Cremation 3 □	Removal from State	ceme	etery, cren	sition (Name of natory or other pi		Date	20c. Lo	ocation - City or	Town, State
Ħ.	it. Pa		4 ☐ Donation 5 ☐ Other (Specify21. Signature of Funeral Service Licen		Glade		etery		18/2004		kersvil	
Ba	Depa Impo any ic		21. Signature of Pulleral Service Licent	W. Sta	-110				Stauffer F Walkersvi			
r.			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused	i the death. [Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				Demon					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as			- DENTE.					V Cont 3
200	LAdminer	100	Sequentially list conditions, harry, leading to minisorate cause. Enter Underlying	b. Jua to (or as	a mineronical	os alle						
	uted Insit	Examiner	Cause (Disease or injury	200 10 (31 48	a concequan	00-317.						
o Î	te be executed ysician and te burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a consequen	ce of):						
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x 68	ertifica ling pt	Physician/Med	IF FEMALÉ:	20- 16								
Вох	eath c attenc for us	clany	in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3	Ectopic pregnan Other (specify)	су		1	23d. Date of deli Month	very Day Year
o	the d by the ached	ysid	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	9□ Unknown	11110 01 0020	, 3	Cities (apociny)					
ď.	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	by PI	Part II. Other significant conditions of	entributing to death be	ut not resultin	ig in the ur	nderlying cause g	jiven in Part I.	23e. Did t	obacco u	ise contribute to	the cause of death?
ord	equire sen sig ould b	ted	CON 65371UE	HOART FA	AILURE				1	Yes 💢	□No 3□Pro	obabiy 4 Unknown
ec	a taw r	Completed							24a. Was	osy	prior to c	topsy findings available ompletion of cause of
a F									1 ☐ Yes	med?	death?	2 🗆 No
Division of Vital Records,	tending Physician: The taw leath. ior: After this certificate has b the funeral director, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	- a - c - c - c	·O			Death (Check only o			
o	g Phys er this eral di	\vdash	27. Manner of Death	28a. Date of Injur (Month, Da)	ry 281	Outpatien b. Time of	28c. Inji	ury at	ng Home 5 Residence 1			ity)
Sior	Attending I ir death. ector: After by the funer	atio	1 Natural 5 Pending investigation		7 (621)	Injury		ork? ⊒Yes 2 ⊒No				
<u>Š</u>		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc		, farm, stre	eet, factory, office	9	28f. Location (S City or Tox	Street an vn, State	d Number or Ru	ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier Physics 29a. Certifying Physics	vsician: To the best of	of my knowled	dao dooth						
	e Hos 24 ho e Fun letely	edicai	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examination	and/or inv	estigation, in my	opinion, death o	occurred at the time,	date and	and manner as I place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licer	nse number		29d. Dat	e signed (Month	
•				MM	9		D.	32171			2/16/	04
	3		30. Name and address of person who d					12000011	LE MO	210	793	
	Sta	te.	RICHARD L. GOU		PO Bo ar's Signatuge	<u> </u>	28 WA	Che les C t	-00 /00		٠٦٥	
臣	Registr	100	31. Date filed (Month Pay, Year) 20	104	Se Di	0						

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			1 = For State Registrar	State of Mar	yland / Depa <i>Ce:</i>	artment of Heartificate of De	alth and N eath		giene 2 () () () Reg. No.	4 07932	
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year						11 010		
7	/Medic						ocation of Death	repruar	4c. County of De	`	
			SINA I HOSPITAL			BALtim	TORE		None	2	
	Funeral Director		5. Social Security Number 135 24 6992	6. Sex 12 M 2 F 7. Age ('In yrs. last birthday) Yrs.		Hours Min.	8. Date of Birt (Month, Day June 26	9. Bi (, Year) 9. Bi (, 1924 Ne	rthplece (State or Foreign Country) WYORK	
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside C						10d. Inside City Limits		
		tor	MD Howar	rd	Ellicott City					1 ☐ Yes 2√∑ No	
		Sirec	10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?		
		rai	3254 Old Fence F			21042	· · · · · · · · · · · · · · · · · · ·		United St		
36		by Funeral Director	11. Marital Status 1 □ Never Married 2 Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Events Armed Forces? and 1 X Yes 2 □ No lf Yes, Give Year or Dates: 10	i	Was Decedent of Hispa If Yes, specify Cuban, I 1 ☐ Yes 2 ★ No 3	eanic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify:		
5-0036		ted	15. Decedent (Specify only highes.	s Education	16a. Dece	dent's Usual Occupation kind of work done duri	on	rina	16b. Kind of Business		
21		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	College (1-4or 5+)		DO NOT use retired)				
d 21		CO	17. Father's Name (First, Middle, L	5+ ast)	Eng:	ineer 18	8. Mother's Nam	e (First, Middle,	Westingh	ouse	
lan lan		To Be	Richard D. Zucker Elizabeth Kittle					e	2		
Maryland			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.								
			Doris J. Zucker/ 20a. Method of Disposition		3254 20b. Place of Dispo	Old Fence		licott	City, MD 2		
nor			1 Notice of Disposition 1 Description	3 □Removal from State	cemetery, crer	natory or other place) canch Churc		5-2004			
Baltimore,	permit. P Departme Importan any injur.		21. Signature of Funeral Service L						Westminst	er, MD ily FH Inc.	
ä	Depar Depar Impo		I Shen Coll	is - little	4	1112 Old Co	olumbia	Pike El	licott Cit	y, MD 21043	
	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
		ner	Immediate Cause (Final disease or condition resulting in death) a. MYOCARD dIA I IN FARCTION Onset and Death							Olisar and Death	
- 7	Examiner			Due fi (or as a c	Due						
	icate be executed physicien and s the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to (or as a c	b. Due to (or as a consequence of):						
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89	tificate ng phy as the	fedicai	0.1	0.	-55/0						
Вох	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)				23d. Date of delivery Month Day Year		
0.		Physician/M	1 Yes 2 No								
٥,		by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						o the cause of death?		
ords		ted to	CARdiomyopAthy					1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
Records,		Completed	Renal Insufficienc		nry	24a. \			utopsy prior to completion of cause of		
al F					1 T			1 ☐ Yes			
of Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
n 01		n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury	28b. Time of	e of 28c. Injury at 28d.			d. Describe how injury occurred		
Sio		al Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	on Discouling the same of the		M 1 Yes	1 ☐ Yes 2 ☐ No				
Division				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					ural Route Number,		
_	To the Hospitel within 24 hours a To the Funeral I completely filled										
	the Ho nin 24 the Fu	ledical	one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						e to the cause(s)		
	To To	29b. Signature and title of compler						1	9d. Date signed (Mon		
1	0		30. Name and address of person v	physici An noosyss February 22, 200 mo completed cause of death (Item 23a) (Type, Print) whelvedere Ave Baltimore, mozic						22,2004	
10	100		FROENTK A	1	0.000	W Belve	dere	Ave B	Altimore	, m021215	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 4	32. Egistrar's	Signature	rack s				<u> </u>	

2	•		1 - ForAMEND ITEM #26 State Registrar WCHD/SH 2/1 1. Decedent's Name (First, Middle, Last)	State of Marylan 8/04 per Dr		artment of F			g. No 2004	0 7 9 3 3
	Physicia /Medic Examin	al	Harold E. Ze			4b. City, Town, o	r Location of Deat	February	13 2004 4c. County of Death	10:20 P M
	uneral		13508 Marsh Pike 5. Social Security Number 6. Sex 15x	7. Age (In yrs. M 2 F 84	last birthday) Yrs.	Hagers If Under 1 Year Months Days	STOWN If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Year) Coul	place (State or Foreign
g		tor	Usual Residence of Decedent 10a. State 10b. County PA Franklin	10c. Cit	y, Town or Lo			Aprili 7,		10d. Inside City Limits 1 ☐ Yes 2 No
U Z I Z I 3-0030 filed within 72 hours after death with the Maryland	Department of results and weather hygienes. The properties of feming 23a or 28e-f show many injury or other traumatic event, the Mudical Examination interest be indifficult at 800s.	by Funeral Director	10e. Street and Number 13243 Midvale Roa 11. Marital Status 1 Never Married 20 Married 3 Widowed 4 Divorced	Id. 2. Was Decedent Ever in U. Armed Forces? 1. Tayes 2 □ No. If Yes, Give Year or Dates: 42-4		10f. Zip Code 17268 Was Decedent of H If Yes, specify Cubs 1 Yes 20(No			g. Citizen of What Cour USA 14. Race - Americ Black, White, Specify: Whi	can Indian, etc.
led within 72 hour	ygrene. her than "natural it, the Medical Ex	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Deced (Give life. I	dent's Usual Occup kind of work done o DO NOT use retired SPETSON	during most of wo	rking [6b. Kind of Business/In	
2 should be fill	marked otf	To Be	17. Father's Name (First, Middle, Last) Ira J. Zercher 19a. Informant's Name/Relationship (Typ.	e, Print)	19b. Mailir	ng Address (Street	Anna		aiden Sumame) City or Town, State, Zip	o Code)
it. Pages 1 and 2 s	intent: If item 27 is njury or other trau		Ruth M. Zercher 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Spouse 20b. F	1324 Place of Dispo Semetery, crem rantham	43 Midval sition (Name of natory or other place Memorial	e Rd. Wa	ynesboro, 2004 cuary 21	PA 17268 Oc. Location - City or To Grantham, F	own, State
			23a. Part) Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ful melu ations that caused the deat	50	S Broad	ST Wayne	esboro, PA	A 17268	Approximate Interval Between Onset and Death
/N Ex	hysician and the burial-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, 1 2 y lessing trimmartial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of the consequence of t	==+11	CINI	ozwe	YUOWS		
The law requires that the death certificate be executed	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ildeath 3□	Ectopic pregnancy	,		23d. Date of delive Month	ery Day Year
w requires that	en signed b ould be deta	þ	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes	acco use contribute to the	he cause of death?
	2 2	Completed						24a. Was an autopsy performe 1 Yes 2	prior to co death?	opsy findings available impletion of cause of
Attending Physicien:	within Extruous after to be and in the function of the functin of the function of the function of the function of the function	ation; To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No Ho 27. Manner of Death 1 ☑ Natural 5 □ Pending 2 □ Accident investigation	ospital: 1 Inpatient 2 I 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur	er: 4 🗆 Nursing H	ath (Check only one) tome 5 Residen 28d. Describe how	ee- 6 X ther (Specif	aughter's home
tal or Atte	al Director ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	ti Route Number,
To the Hospital or	within 24 rous after beaut. To the Funeral Director: After this completely filled in by the funeral di	Medical		cian: To the best of my kno er: On the basts of examina and manner stated.			pinion, death occu	urred at the time, dat		o the cause(s)
J/D	X/ * F 9		Judene H	mpleted cause of death (Item	n 23a) (Type,	Print)	3623	Te	brung 1	6, 7004
5	Sta Registr		31. Date filed (Month, Fig. 2018 21	32. Redistrar's Signa	atured.	peter	er la	mpri Ki	1 telen	town Mil

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma		d / Depa		Health	and M	lental Hygi	•			
	Physici /Medio		Decedent's Neme (First, Middle, Las Neme (First, Middle, Las) Neme (First, Middle, Las) Neme (First, Middle, Las)	Mario Zar	mich	ieli				2. Date of Death Month February	Day Yee 7 16, 200	3. Time of Death 4 2:45 A M		
	Examir Funeral	er	4a. Fecility Name (If not institution, give Prince George's H	ospital Co	(In yrs. la	ast birthday)	4b. City, Town, Ch If Under 1 Yea Months Days	everl	Y er 24 Hrs.	8. Date of Birth (Month, Dey,	Year) 9. E	e George 's Birthplace (State or Foreign Country)		
	Director		Usuat Residence of Decedent 10a. State 10b. County		70 10c. City	Yrs.				Oct 15,	1933	New York 10d. Inside City Limits 1⊠Yes 2□No		
	h with the Mi 13s or 28s-f	al Directo	Maryland Prince G 10e. Street and Number 8202 Oliver St				New Carr 10f. Zip Code 2	011to 0784	n	10	g. Citizen of What	Country?		
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other than "natural", or Items 23a or 28a-f ehow amy rigury or other traumatic event, The Medical Examinar must be notified at ODGe.	by Funeral Director	11. Maritat Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 2 N If Yes, Give Year or Dates:			Was Decedent of f Yes, specify Cu			ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W Specify: V	11.5		
Baltimore, Maryland 21215-0036	s within 72 ho jiene. r than "natur the Medical.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th	ucation de completed) Coltege (1-4or 5-	+)	(Give	dent's Usuat Occi kind of work don DO NOT use retir Barb	e during mo ed)	ost of worki	ing	6b. Kind of Busines	ivate		
ryland ;	hould be filed d Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, Last) Marcello Z am 19a. Informant's Name/Relationship (7)			10h Mailir	ng Address (Strae			Mary Ma		Tio Code)		
e, Ma	1 and 2 s Health an tem 27 le p		Rose Zammichieli 20a. Method of Disposition	(Wife)	20b. Pl	8202 ace of Dispo	2 Oliver	Stre	et, N	Ew Carro	ollton MD	20784		
Itimo	nit. Peges artment of ortent: If I injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Paneral Service Licen)		sapeal	matory or other pl CE Crema	tory			Beltsvil			
B B	Deparent Impo		21. Signature of Pheral Service Licensee 22. Name and Address of Facility Rendon/ Hale Funeral F 9013 Annapolis Road, Lanham MD 20706 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
68760,	Physician /Medical Examiner and physician and physician and physician and the prical-transit	dical Examiner	speck, or neart failure. List day of the failure is	a. Pulmor Due to (or as a Due to (or as a d.	nary consequence M	Fibros ence of): (yloma ence of):						Interval Batween Onset and Death 6 months 6 months		
P.O. Box (the death certificate by the attending phy ached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of the control	2 Fetal	death 3 □	Ectopic pregnand Other (specify)	су			23d. Date of c Month	delivery Day Year		
	The law requires that the de ate has been signed by the a page 2 should be detached	ed by PI	Part II. Other significant conditions of Sepsis	ontributing to death bu	t not resu	lting in the u	nderlying cause g	iven in Part	1.			to the cause of death? Probably 4 XUnknown		
al Reco	r: The law re reate has be r. page 2 sho		Respiratory Fai	lure						24e. Was an autopsy perform	ed? prior to death' ⊠No 1 □ Ye	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)		
Division of Vital Records,	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ition; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	,	ER/Outpatien 28b. Time of tnjury	28c. Inju	ther: 4 🗆 N	lursing Ho	n (Check only one ne 5 ☐ Resider 28d. Describe how	nce 6 Other (Sp	pecify)		
Divis	s after dea is Director of in by the	Certification;	3 Suicide 6 Could not be determined	28e. Ptace of triju building, etc	ry - At hor . (Specify,	me, farm, str	eet, factory, office			28f. Location (Stre City or Town,		Rural Route Number,		
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medicat Examone)	ysicien: To the best of liner: On the basis of and manner sta	examinati	vledge, death ion and/or inv	estigation, in my	opinion, de	ath occurr	ed at the time, dat	te and place, and d	ue to the cause(s)		
	5 Twit	2	29b. Signature and Ittle of certifier	Shigh			2	6 2			d. Date signed (Mo.	nth, Dey, Year)		
	(5)		30. Name and address of person who of Revathy Murthy, 31. Date filed (Month, Day, Year)) Lan	dover	Road, C	hever	ly MD	20785				
	Sta Registr		FEB 1 7 2004	See	, &	Los	W							

State of Maryland / Department of Health and Mental Hygiene 2004 07935 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** MARCH 2004 1050 AM Robert E. Bauer /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ F 15. Maryland Director 213-34-4073 67 Jan. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f ahow mortant: printing to when the most permitted at a new injury or other traumatic event, the Madical Examinar mantal to notified at 1 ☐ Yes 2 No Harford Abingdon Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4023 East Baker Avenue 21009 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) accounting Elementary/Secondary (0-12) College (1-4or 5+) self-employed certified public accountant 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leamer Brooks John E. Bauer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joyce A. Bauer/wife 4023 East Baker Avenue, Abingdon, Md. 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State

1 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 3/9/2004 Baltimore, Md. 21. Signators of Funeral Service Licensele 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. nna 610 W. MacPhail Road, Bel Air, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 50 **Physician** 0 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): the attending physicien a hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 4 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 8, P.O. 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 57 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? 22 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 | Homicide cirtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier MATO empleted cause of death (Item 23a) (Type, Print) 30. Name and address of Fallston 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

BALLER KOBERT

			1 - State Amend Item	State o #17 per	of Marylar fh G82	nd / Depa 29 3/42/	irtment of H	lealth and I Death	Mental Hygi	ene g. No. 201	04 07936
	Physici /Medic		1. Decedent's Name (First, Middle, La	ailey					2. Date of Death Month		3. Time of Death 4145 A M
<i>\$</i>	Examin	er	4a. Facility Name (If not institution, give		mber)		* '	Location of Deatl	1	4c. County of D	eath
	Funeral Director			Cal Sex 1□M 2√2F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days		(Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	ט		Usual Residence of Decedent						11-25-0	19	
	show	ō	10a. State 10b. County		10c. Ci	ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-f	Director	Md NA 10e. Street and Number			Bali	10f. Zip Code		10	g. Citizen of What	
	h with 23a or 31 be	al D	1700 N. Payson	Street			21	217		USA	
	r deal	Funeral	11. Marital Status	12. Was Dec Armed Fo		J.S. 13.	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23a or 28a-f show ant, the Macical Exam or must be maiffed at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes If Yes, Gi Year or E	2. No iveX Dates:		☐ Yes 2☐No	Specify:		Specify:	Black
21215-0036	72 hou	ted	15. Decedent's E	ducation		16a. Deced	lent's Usual Occup	ation	ting 1	6b. Kind of Busine	ss/Industry
2	vithin 7	Completed	Elementary/Secondary (0-12)	College (life. L	OO NOT use retired	()	~iiig		
d 2	filed v Hygie other t	e Co	2nd grade 17. Father's Name (First, Middle, Lass	1 . n		Ho	nemaker	18. Mother's Nan	ne (First, Middle, M	Own Hom	e
Maryland	and be fental rked o	To Be	Levin	Levin K	obinson Roberts	ion-		Betty			NKN
lary	2 shou and N Is mai		19a. Informant's Name/Relationship	Туре, Print)			•		ral Route Number,	- ,	e, Zip Code)
e,	1 and Health Health Her tr		Charles Doughty 20a. Method of Disposition	So			N. Payso sition (Name of	n Street	, Baltimo	ore, Md.	21217
nor	Pages nent of P ant: If its ury or o'		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specie		State	cemetery, cren	natory or other plac			,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I Department of Health and Mental Hygiene. I be more as a second that them, and the them are second to the than "natural", or them 23 a or 28 a 1 show any injury or other traumatic avent, the Marical Examination at the multipled at once.		21. Signature of Funeral Service Lice		We	odlawn 22	Com. Name and Addres	ss of Facility		altimore	M CONSTRUCTION
<u> </u>	e e e e		Justes	lag			arch F.H.		_1101 E.	imore, Mo North Av	e. 21202
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that one cause on	caused the dear ach line.	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
70	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Dun to	(or as a consec	MONI	1				
	Examiner			- Sue 10	EPS I	S					
_	ש ש	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or as a consec	quence of):	1400 +	-	1 .		
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	uence of):	Newl	Fai	lure		
8760,	cate be ex physician the buria	dical E		d	O						
9		Aedio	IE ECHALC.			*					
Вох	it the death certific by the attending p tached for use as	ian/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome of pregn birth 2 Peta	al death 3 □	Ectopic pregnancy			23d. Date of of Month	delivery Day Year
o <u>.</u>	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregi 9□ Unkn	nant at time of o	death 5∟	Other (specify)				,
۵.	es tha gned be de	by Physician/Me	Part II. Other significant conditions	contributing to d	leath but not res	sulting in the ur	derlying cause give	en in Part I.			to the cause of death? Probably 4 Unknown
Records,	w requir been si should	letec							24a. Was an		
_		Completed	*	,					autopsy perform	prior to death	
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital: X			Othe	200	th (Check only one		
ō	g Phys er this eral di	٦. ا	1 Yes 2 No 27. Manner of Death	28a. De te	of Injury	ER/Outpatien 28b. Time of	28c. Injury	4 ⊔ Nursing H	ome 5 Residen 28d. Describe hov		oecify)
ion	ading ath. or: Afte	atlo	1 Ølatural 5 ☐ Pending 2 ☐ Accident investigation	n	nth, Ďay Year)	Injury	M 1 🗆	(? Yes 2 □No			
Division of Vital	l or Atte after de Directo	Certification:	3 Suicide 6 Could not be determined	280. Place	e of Injury - At h ling, etc. <i>(Speci</i>	iome, farm, stre fy)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
	Hospita 4 hours Funeral ely fillec		(Check only 2/ Medical Exa	miner: On the b	pasis of examina	owledge, death	occurred at the timestigation, in my or	ne, date and place pinion, death occu	, and due to the cau	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the I within 2 To the I complet	Medical	one) 29b. Signature and title of certifier	and man	nner stated.	·	29c. License			d. Date signed (Mo	
)	r s h ŏ		JONGNICO	Lam	l- Mic		D.35	1203	n	nona 11),2064
(3		30. Name and address of person who	completed caus	se of death (Iter	(2)	Print)	10 Lln	OLLO	Ranh.	200
	Sta	ta	31. Date filed (Month, Day, Year)	32. F	Registrar's Sîgna	ature &	SECOU	15 170	SILLE	, Duxil	YVU IVV
	Registr		MAR I	2 ZUU4	Bentone.	1 650	Sept Sept Sept Sept Sept Sept Sept Sept				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Sylvia Ann Bradford Malch 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklinsquare ROSESO14 HOSTITOI imol If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Country)
Illinois 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Dec. 16,1938 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Min. Hours 1 □ M 2XX€ 356-30-4067 65 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County f Health and Mental Hygiene. item 27 is marked other than "nature!", or Iteme 23a or 28a-f ahov other traumatic event, the Medical Examinar must be notified at or 28a-f ahow 1 Yes 2XXIIo Maryland Baltimore Rosedale Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 2038 Flintshire Road, Apt. 101 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: U.S.A. If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☑ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: if item 27 is marked other than ", any injury or other traumatic event, it a Mesona. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cosmo Salvadore Venuto Katherine Caputo ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Katherine Harrington (Daughter) 719 Pumping Station Road, Hanover, Pa. 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 03/15/2004 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A 21 Signature of Funerel Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Pert1 Frief the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UN9 Physician concer /Medical **Examiner** 25 DINSTON Sequentially list cure for sif any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 ☐ Live birth ţō in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, page 2 should be 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 22 No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2/ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 ☑Natural 2 ☐ Accident 5 Pending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 014801

State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 004 07938 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1820 p^M David Alan Bowles March 8 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Outer loop 695 north of Joppa Road Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/20/1952 Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1**X** M 2□ F Maryland 217-48-8874 51 Director Usual Residence of Decedent 10d. Inside City Limits r 28e-f show 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 No Director Baltimore MD Kingsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number rai', or itams 23a or Examiner must be U.S.A. 21087 12315 Jerusalem Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: "naturei" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fucchina Construction 12 Operating Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic evi Regina Catherine Huber Dean Bowles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 12315 Jerusalem Road - Kingsville, MD 21087 Barbara L. Bowles (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1 Department of H Important: If its any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 03/12/2004 Baltimore, Maryland * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, MD Vasas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nole /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 Completed by Physician/Medical as the IF FEMALE esn. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 2 8 2 No certificate 1 Yes 2 🗌 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ₩Other (Specify) at SCENE Hospital: Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA d. Jescri. how injury occurred

28f. Location (Street and Number of Ruid Route Number, City or Jown, State) 28c. Injury at Work? 1 Yes 2 □ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending -04 nours after death.

nerel Director: A
filled in by the fu investigation M 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 9 2004 OCME Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 OllAKW

State Registrar nth, Day, Year)
D 1 2 2004

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

		1	For State Registrer	State of Maryland	d / Departme <i>Certifica</i>	nt of Health and I te of Death	Mental Hygie		07939
	Physicia /Medic	ın	1. Decedent's Name (First, Middle, Las		500		2. Date of Death Month	Day 8 2004	3. Time of Death 7:25 AM
	Examin		4a. Facility Name (If not institution, give	^ ~		town, or Location of Death	h C. H.A	4c. County of Deeth	A
	Funeral Director		5. Social Security Number 6. Se	of Baltimo × 2XF 7. Age (In yrs. Ia		er 1 Year If Under 24 Hrs.	8. Date of Birth Month, Day, Ye	9. Birthp Coun	lece (State or Foreign try)
	e Maryland e-f show lifted at		10a. State 10b. County	A 10c. City,	Town or Location	- I timor	e	11	0d. Inside City Limits 1 No
3	ath with th	Funeral Director	10e. Street and Number	olfield F	Ive	ip Code 212	15	. Citizen of What Coun	.A
9	rei', or items		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give, Year or Dates:		edent of Hispanic Origin? (S ecry Cuban, Mexican, Puert 22 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify:	an Indian, etc. ACK
2 2 3	permit. Pages 1 and 2 should be tied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If tien X7 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at ODGs.	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		life. DO NOT	ork done during most of wor	rking 16t	b. Kind of Business/Ind	dustry
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נ' בּ	1 and 2 sho Health and em 27 is m ther traum		19a. Informant's Name/Relationship (7	nrue,	19b. Mailing Address 10 50 9 ace of Disposition (Na	SS (Street and Number or Ru	"I 110	~ ^^ -	Der MO
	iit. Pages artment of I ortent: If its injury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Fune al Service Licen	Removal from State	ING M	other place) Emurid 3 Ind Address of Facility L	1104	MARIL	Ano
ב	permit. Departr importr any inj		Willie Et	full	4607) WEERTY	H.B	with Mr	2007
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	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ					
,00	ate be executed hysician and the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ience of):				
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.O.	The law requires that the death certilicate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 moeths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic			23d. Date of delive Month	ny Day Year
olds, r	equires that en signed b ould be deta	5	Part II. Other significant conditions of	intributing to death but not resu	olting in the underlying	cause given in Part I. ESENERATUE	23e. Did tobac	cco use contribute to th	ne cause of death? ably 4 ∐Unknown
וומו חפרו	cate has be page 2 sh	Completed	Joint Diseas				24a. Was an autopsy performed	d? death?	psy findings available inpletion of cause of
2	ysicien is certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpatient 3 0	Othor	ath (Check only one) Home 5 ☐ Residence	e 6 □Other (Specify	()
io Holeivi	ath. r: After the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how		
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director. page 2.	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify,			City or Town, S		
	e Hosp 24 hou e Fune letely fi	edical	29a. Certifier 1 □Certifying Ph (Check only one) 2 □ Medicel Exem	ysician: To the best of my know iner: On the basis of examinati and manner stated.	wledge, death occurre ion and/or investigation	d at the time, date and place on, in my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	(MAD)		9c. License number	29d.	. Date signed (Month,	4
			30. Name and address of person who	ompleted cause of death (Item		KES-000) (1)	arch 8,	900 A
	Ø CO		Ruth L. Meric 31. Date filed (Month, Day, Yeer)	32. Registrar's Signat	i Hospir	tal of B	eltimore	2	
	Sta Registr		MAR 1 2 2004	A. Nogistrai o olgitat	1				

DHMH 17 Rev 1/2001

Known as Bronson, Victorià

State of Maryland / Department of Health and Mental Hygiene 2004 07940 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March Day 2004 **Physician** Bidinger Margaret Ann 10 3:15a /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2115 Frizzelburg Road Apt B Westminster
| Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Months Days Hours Min. | Mar 6 1956 Westminster Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 □ M 2 □ √F 219-66-4849 48 PA Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County in than "natural", or Itams 23a or 28a-1 show the Medical Exeminer must be notified at Md Carrol1 Westminster 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 2115 Frizzelburg Road Apt B USA by Funeral Pages 1 and 2 should be fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 1/2 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married X 3 ☐ Widowed 4 ☐ Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: white Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) health care nursing aide permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Itam 27 is marked other til any injury or other traumatic event, Im OMCB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Malick Janet Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Malick (mother) 11305 Anthony Hwy., Waynesboro, PA 17268 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 20a. Method of Disposition 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) All County Cremation | 3-11-04 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Paropolaight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OUARIAN (ARCINOMA /Medical Due to (or as a consequence ol) 64 EARS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Dther (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 일 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place ol Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COURISHANKAR MOANNA 700 A POOLE RO WESTMINSTER 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

		1 - For State Registrar	State of I	Maryland	/ Depa	artment of F	lealth a	and M	ental Hyg	jiene	200	4 07941
Physic	ian	Decedent's Name (First, Middle, L	*						2. Date of Dea Month	th Day	Year	
/Medi		James L. Cle							March	11,		11:38 A M
Examir	ner	4a. Facility Name (If not institution, gi Gilchrist Cente		er)		4b. City, Town, o		of Death		4c. 0	County of Dea	
				Age (In yrs. las	t birthday)	Tows (24 Hrs.	8. Date of Birth			timone httplace (State or Foreign
Funeral Director		577-09-7496	1 € M 2□ F	86	Yrs.	Months Days	Hours	Min.	March 1	. Year)	C	shington, DC
D.		Usual Residence of Decedent							1.100 00.10	-, , ,	, , , , , ,	one engineerity to
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i Z i 3-UU30 ithin 72 hours after death with the Marylan nen "naturel", or items 23a or 28a-1 show medical Examiner must be motilied at	Completed	15. Decedent's I (Specify only highest g	Education rade completed)		(Give	lent's Usual Occup kind of work done	durina most	t of working	ng	16b. K in	d of Business	s/Industry
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iand ld be fill ental Hy ked oth	To B	Louis L. Cle	iico					theri		erag	•	
shou and M s mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Numbe	r or Rura	Route Number	, City or	Town, State,	Zip Code)
and 2 saith and 27 i	1	Mr. Ronald Revill	le (step-			Denise I	Dr., F	ores	t Hill,	MD	21050	
intimore, maryis int. Pages 1 and 2 should ariment of Health and Mer ortant: if item 27 is marke injury or other traumatic e.		20a. Method of Disposition 1 □ Burial 2 🗡 Cremation 3	Removal from Sta		e of Disponetery, cren	sition (Name of natory or other plac					•	r Town, State
Pages tment of tant: If it		* 4 □Donation 5 □ Other (Spec	ify)	Bayv		?rematory						, Maryland
Baltimor permit. Pages Department of I Important: If it eny injury or o		21. Signature of Funeral Service Lice	ensee			Name and Address						
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BOX OC Beath certifice attending or I for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregnance	y					22	3d. Date of de	dison
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Phys or this aral din	 	1 Yes 25 No 27. Manner of Lath	28a. Date of li	injury 28	VOutpatient Bb. Time of	28c. Injun Work	4 🔲 1901	-	ne 5 ☐ Reside 8d. Describe ho		occurred	±14)
nding P th. :: After e funera	ation	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury		k? Yes 2∐N					
VISI	ertification:	3 Suicide 6 Could not determined	28e. Place of	Injury - At home , etc. (Specify)	, farm, stre	et, factory, office		2	8f. Location (Str City or Town	reet and	Number or R	ural Route Number,
itai or rs afte al Diji	Cert		Dallaling,	, etc. (Opecity)					City or Town	, State)		
the Hospital or Attending in 24 hours after death. the Funeral Director: After inpletely filled in by the fune	edical	29a. Certifier Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner: On the basis	s of examination	edge, death and/or inv	occurred at the timestigation, in my of	ne, date and pinion, death	d place, a h occurre	nd due to the ca d at the time, da	iuse(s) a ite and p	nd manner a: lace, and due	s stated. e to the cause(s)
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Med	29b. Signature and title of certifier	and manner	stated.		29c. License	e number		29	d. Date	signed (Mont	th, Day, Year)
F > F 0	İ	> /YINLUKIL	uvc	uch	1	1)3	909	19		3-	11-0	4
10		30. Name and appropriate of person who	completed cause of	of death (Item 23	За) (7) ре, 1	Print)		•			•	/
IV		160dey W	11110	us m	4	6601 N.	Charle	es St	., Balt	·. , 1	1D 212	204
Sta Regista		31. Date filed (Month, Day, Year)	32. Regi	ismar's Signatur	B As	hoart 1						

State of Maryland / Department of Health and Mental Hygiene 200407942 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 9, Lillian Church Lorraine March 2004 10:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5606 Ranelagh Road White Mulsing Mulsing Min. Sept. 22,1937 Maryland White Marsh Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 YF 66 218-34-1840 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5606 Ranelagh Road 21162 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give White. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Klima Lillian Oliver 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Marlan A. Church (husband) 5606 Ranelagh Road, White Marsh, MD 21162 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State jo <u>=</u> 1 \$\overline{\mathbb{D}}\$ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem'l Gard 3/12/2004 Baltimore, Maryland 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that raused shock, or heart failure. List only one cause on each lin the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Gen **Physician** RIAN resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) as the the attending IF FEMALE: Division of Vital Records, P.O. Box use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ŏ Month Year Day signed by the aid 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2. No 1 Yes 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy certificate 1 Yes 2 No 1 ☐ Yes 2/2 To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural
2 Accident 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 1 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination anglor investigation, in my opinion, death occurred at the time, date and place, and due to the anglor manner stated. Medical 29a. Certifier ation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number e and address of 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 8, 2004 **Physician** 5:00 a M Margaret V. Crabbe /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) **Examiner** Harford Abingdon 3408 Brooks Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) | April 24, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2√2F 215-18-9338 82 $^{\prime}1921$ Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at 1 Yes 2 No Director Harford Abingdon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21009 United States 3408 Brooks Avenue Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 years College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I and 2 should be Elizabeth Henderson George W. Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at
Importent: if Item 27 is
any injury or other trau 3408 Brooks Avenue, Abingdon, Md. 21009 Kenneth Crabbe/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 3/11/04 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ()UMS HOUTE MYOCOMAINC INTOMORON disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Val Jeny onouny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): 68760. signed by the attending physician I be detached for use as the buria The law requires that the death certificate be Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ DIASTOLIC CONGOSTIVE INGIANT 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page 2 No 1 Yes 2 200 After this certifical funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 2 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 701 20390 Rec 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 9712 Belair Road, Baltimore, Md. 21236 Charles F. Hoesch, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 2 2001 Registrar

			a otale	State of Maryland / Dep	partment of Health and ertificate of Death			07944
			Registrar 1. Decedent's Name (First, Middle, Last)	0	Timodic or Bodin	2. Date of Death		3. Time of Death
	Physici /Media		Olivia	Carr		March	200°	4 1:45PM
	Examir		4e. Fecility Name (If not institution, give st	1 1	4b. City, Town, or Location of Dea	ith P n	4c. County of Dea	and discountry to the second
	Francis		5. Social Security Number 6. Sex	uare Hospilal		s. 8. Date of Birth	9 Bi	tholece (State or Foreign
b	Funeral Director		218-46-7472 10		Months Days Hours Mir	Month, Day, Yes	950 p	rthplece (Stete or Foreign ountry)
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location			10d. Inside City Limits
	Maryli fied a	ţoţ	ma. N	IA BY	altmore			1 Ses 2 □ No
	th the	Director	10e. Street and Number	o of ant	10f. Zip Code	10g.	Citizen of What C	ountry?
	ath wi	ral	2401 St. Ste	phens Ct. 1721	21216		USA	+
	Hems Inverse	Funeral	11. Marital Status 12 1 □ Never Married 2 □ Married	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
98	ral', or	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specity:		Specify:	Slack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show the Modical Exerting Frank Re trufflied at	Completed	15. Decedent's Educa (Specify only highest grade	completed) (Giv	edent's Usual Occupation re kind of work done during most of w	orking 16b.	Kind of Business	/Industry
12	filed withir Hygiene ather then ant, the M	ошо	Elementary/Secondary (0-12)		sed Day Care +	vider	Day	Care
and 2	be filed ntal Hygie od other	Be C	17. Father's Name (First, Middle, Last)			ume (First, Middle, Maid	en Sumame)	
<u>Xa</u>	should be ind Mental imarked c	To	Hubert	Bert		rene	Job	e
Mary	d 2 sho		19a. Informant's Name/Relationship (Type	1 = 1 - 1 - 2110	ling Address (Street and Number or F	Al May	2 01	1 2 2 /
	t Health Hem 27 other tr		20a. Method of Disposition	20b. Place of Disp	position (Name of	Date 20c.	Location - City or	
more,	Pages nent of int: If Its ury or o		1 Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	2 Lon Com 3-1	6-04 la	nsdown	o md.
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or Items 23a or 28a-f show any futury or other traumatic event, Ite M. dical Exacting 1. and to rutified at ODGe.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility		34050	U. Franklinst.
	40 5 e a		23a. Part1. Enter the dispase, or complication	vallace IV		meral Service	BALTO	mo 3/229
	Physician		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	Lack	ic or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	NOC!			
4	Examiner		Sequentially list conditions, b.					
	nsit	nlner	if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
o î	execu an and rial-tra	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
8760	icate be executed physician and s the burial-transit	dlcal	d.					
9		/Mec	IF FEMALE:	c. If yes, outcome of pregnancy			_	
Box	death of attendance	clan	23b. Was decedent pregnant in the past 12 menths?	1 Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	livery Day Year
о. О	that the de led by the a detached t	Physician/Me	9 Unknown	9□ Unknown				
	88 50 8	by	Part II. Other significant conditions control	7.	underlying cause given in Part I.		11	the cause of death?
Records,	w require been si should b	eted	TO BY O BE	23,14				obably 4 Unknown
Re	The law ate has page 2:	Completed				24a. Was an autopsy performed?	death?	stopsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical examiner?		26. Place of De	1. Yes 2 □ N ath (Check only one)	lo 124es	2 No
ot v	Phys this al di	2	1 ☐ Yes 2 No Ho	spital:		Home 5 Residence		cify)
ono	ding h. After funer	tlon	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
Division	after Attendi after death. Director: A d in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st		28f. Location (Street	and Number or Ru	ıral Route Number,
	itslor irs afte rsl Dir led in			building, etc. (Specify)		City or Town, Sta		
	To the Hospitsl or Ati within 24 hours after d To the Funersl Direct completely filled in by	edical	29a. Certifier Check only one) Certifying Physic 2 Medical Examine	cian: To the best of my knowledge, dea er: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place average investigation, in my opinion, death occ	e, and due to the cause(urred at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	ro the within to the comple	Me	29b. Signature and title of centrer	n dillamor stated.	29c. License number	29d. D	ate signed (Mont	h, Dey, Year)
			Valaniel &	1 mes	D53694	-	3/12/0	4
	5		1	pleted cause of death (Item 23a) (Type		X . 3	0-1	d. 21237
7.1		10	Danie L Shinner	32. Registrar's Signature	anklin Square	Dure B	ello. M	4.21211
	Sta Registr		MAR 1 2 2004	/	Sparker			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar		aryland / Di	epartment Certificate	of Health and of Death		Reg. No.	104	0794
-	Physic /Medi		Decedent's Name (First, Middle, La	Kevin	Michael	Crawfor	d	2. Date of D Month March	Day 10, 200	Year 4	3. Time of Death 11:35 P ^M
P.	Examir	ier	4a. Fecility Name (If not institution, giv. 1618 Hempstead Co			4b. City, To	Joppa	eath	4c. County Ha	of Death rford	d Co.
	Funeral Director		219-76-7463	ex 7. Ag ☐M 2☐F	e (In yrs. last birth 45 Yı	Months		in. (Month, D	rth ay, Year) 21,1959		place (State or Foreign ntry) cvland
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Har	ford	10c. City, Town	or Location		Topps		1	0d. fnside City Limits
	th with the 23a or 28s	ai Director	10e. Street and Number 1618 Hempstead			10f. Zip C	21085	Joppa	10g. Citizen of V		•
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Medical Examinar must be natified at	by Funeral	11. Marital Status ¥⊠Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 1 1 1 Yes, Give Year or Dates:	Ever in U.S.	13. Was Decede If Yes, specifi 1 Yes 2	nt of Hispanic Origin? y Cuban, Mexican, Pu y No Specify:	(Sp <i>ec</i> ify Yes or Nerto Rican, etc.)		- Americ k, White,	an Indian,
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) Colfege (1-4or 5	+)	ife. DO NOT use	done during most of v retired)	vorking	16b. Kind of Bu	siness/Ind	dustry
land 2	ould be filed Mental Hygin arked other atic event, the	To Be Co	17. Father's Name (First, Middle, Last) Charles J. Crawfo			rapnic .		lame <i>(First, Middle</i>		θ)	ts
, Mary	1 and 2 should be Health and Mental Iom 27 is marked of	_	19a. Informant's Name/Relationship (19m. Loretta B.	,, , , , , , , , , , , , , , , , , , , ,			Street and Number or dale Road	Rural Route Numb		State, Zip	Code) 21224
imore	Pa ant: ury		20a. Method of Disposition 1X3 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	isposition (Name crematory or othe wn Cemet	er place)	Date /2004	20c. Location - Baltin		wn, State Maryland
Balt	permit. Pa Departmer Important eny injury once.		21. Sa ature of Funeral Service Licen	. Can	20	Duda-Ri 7922 Wi	Address of Facility ICK Funera Se Ave. I	hindalk	Dundal	c, In	
()	ilicate be executed / Medical Examiner as the burial-transit	Examiner	232 Part. Enter the disease, or companies to the companies of the companie	a. Proper Due to fras a Due to (or as a c.	Sive Ma a consequence of)	etifocal a	encoences h	a log atty	(pmL)	c)	Approximate Interval Between Onset and Death
.O. Box 68760,	.= C0 es	Physician/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal death	3 ☐Ectopic preg 5 ☐ Other (spec			23d. Date Mon	of deliver	ry Day Year
rds, P.	quires that an signed b uld be deta	by	Part II. Other significant conditions or	entributing to death bu	it not resulting in th	e underlying cau	se given in Part I.		obacco use contri Yes 2 □ No		a cause of death?
Vital Records,	The law resale has bee	Completed						24a. Was autor perfo 1 \(\text{Yes} \)	osy pr rmed? de	ere autop for to com sath?	sy findings available apletion of cause of
Division of Vita	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	tion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending Investigation	Hospital: 1 ☐ Inpatier 28a. Date of fnjun (Month, Day	nt 2 ER/Outpa y Year) 28b. Tim Inju		0	eath (Check only come 5% Residue) 28d. Describe)
Divisi	ial or Attending s after death. al Director: After ed in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of fnju building, etc	ry - At home, farm, . (Specify)			28f. Location (S City or Tox	Street and Number vn, State)	r or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the funeral birection of the funeral filled in the funeral filled i	edical	29a. Certifier 1 [™] Certifying Phy (Check only one)	rsicien: To the best o iner: On the basis of and manner stat	examination and/o	eath occurred at I r investigation, in	he time, date and place my opinion, death occ	ce, and due to the curred at the time,	cause(s) and man date and place, ar	ner as sta nd due to t	ited. the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier	Daring.	mD		icense number	D	29d. Date signed	(Month, D	ay, Year)
	6		30. Name and address of person who c Charles Davi	s, M.D. 7	25 West	pe, Print) Lombard	St. Balti	more, Ma	ryland		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra 2, 2004	r Signature	1 6138	120				

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 1 1 - Statement Items 23a, PtI, 25 per ME, G829, Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** FEE. 16:04 BOON 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Babling Ref If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Mar. 26, 1947 THE TOHNS HOPKINS PILAL Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M XX 219-17-4779 56 Korea Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Director MD Howard Ellicott City 10f. Zip Code 10a. Citizen of Whet Country? 10e. Street and Number ftems 23a Korea 14. Race - American Indian, White, etc. Completed by Funeral 21043 3337 Sonia Trail 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married X Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 0 Specify: Specify: Korean 3 Widowed 4 Divorced natural Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then College (1-4or 5+) Elementary/Secondary (0-12) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be if Health and Mental I Pages 1 and 2 should be Ki Chang Lee Keum Ae Yoo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jae Ho Choo/Brother-in-law 207 Meadowvale Road Timonium, MD. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 0 = 0 1 Deurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Crestlawn Memorial2/10/2004 Marriottsville, Md/ * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Advess of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licer 5555 Twin Knolls Road, COlumbia, Md 21045 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or shock, or heert failure. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Complications of Multiple Myeloma Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of), Examiner Physician: The law requires that the death certificate be executed use as the burial-transit CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): sician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 1□ Yes 2FINO 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1_Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1_Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 ☐ Accident investigation the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wo JOSHUA TEARL MAN 600 A 31. Date filed (Month, Day, Year) 32. Registrar's Signatu Registrar 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ELOZ Month **Physician** HEW MARCH 10 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner RANDALISTOWN BALTIMORE NORTHWES HOJPITAL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 85 213-12-6544 Director Baltimore, MD 3-11-1918 Usuel Residence of Decedent with the Manyland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-1 show any injury or other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No MD Baltimore Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 7019 Dogwood Road 14. Race - American Indian, Black, White, etc. Completed by Funeral 21244-2607 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 No Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white If Yes, Give Year or Dates: 3 SWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Greater Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Medical Center 4+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) To Be Pasquale Celozzi Palma Canelli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) son 7019 Dogwood Road, Baltimore, MD Matthew J. Celozzi II 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 3/15/2004 Baltimore,Maryland Dulaney Valley 22. Name and Address of Facility Joseph N. Zannino Jr FH 21. Signature of Funeral Septice Liesnsee 263 S. Conkling St.Baltimore, MD 21224 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 00 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 DOA Medical Certification; To this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. uneral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie MARCH 10,2000

Registrar
DHMH 17 Rev 1/2001

NWH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2004 ▶

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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	Examir	ner	4a. Facility Name (If not institution, give		nber)		4b. City,		Location o	f Death		4c	County of De		
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	he Ho in 24 he Fu	edical	(Check only 2 Medical Exami	ner: On the bas and manne	is of examina	ation and/or inv	estigation, i	n my opi	nion, death	occurre	d at the time.	date and	place, and du	e to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 2001 07949 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7° 2004 ear March **Physician** 18:19 John Frederick Dimler, Sr. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Carrol1 Westminster Birthplece (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 17, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□F Months Days Hours 1934 69 220-30-6823 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other transfer any injury or other traumatic event, I'm Majical Examinar measure. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No MD Carrol1 Finksburg Director 10e. Streel and Number 10f, Zip Code 10g. Citizen of What Country? 21048 USA 2428 Clydesdale Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ™ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White δ 3 Midowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steam Fitting Ŀ Steam Fitter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (Unknown) John Edward Dimler Gladys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John F. Dimler, Jr. (Son) 2428 Clydesdale Road Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Crestlawn Mem. Gardens 3/11/04 Marriottsville, MD ¹ 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee PA I FUNERAL HOME & CHAPEL, PA (Box 195) Dian Sykesville, MD 21784 (410)-795-1400 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. proximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00051924 2000 30. Name and address of person who completed cause ol death (Item 23a) (Type, Print) P. Henc Herbert erson J. MD 2973 Marches Manchester MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day JAMES STANLEY DePUY FEB.2,2004 /Medical 4:404a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9612 RANDALL DRIVE WHITE PLAINS
If Under 1 Year If Under 24 Hrs. CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JUNE 21,1933 Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 JM 2 F 70 Yrs. 572-36-7747 Director CA. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiene.
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1 ☑ Yes 2 ☐ No USAF
If Year or Dates: KOREA Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FAA 12 ASST.DIVISION CHIEF U.S.GOVT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be G RUSSELL DePUY ဂ္ KATHERINE NELSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELSIE L.DePUY-SPOUSE 9612 RANDALL DR. WHITE PLAINS, MD. 20695 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: if any injury or once. MARYLAND VETS, CEMETERY 2-10-04 CHELTENHAM, MARYLANI 21. Signature of Fufferal Service Licenses M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on-each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 H NO 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident al or Attence after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital o within 24 hours af To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 0 03 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 1 0 2004

State of Maryland / Department of Health and Mental Hygiene 2001 07951 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Daylo Month **Physician** 2006 Anthony Grisbach Joseph lare /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good Samaritan Nursing Center Baltimore N/A8. Date of Birth (Month, Day, Year) March 30, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F 72 Maryland 212-28-3320 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 21811 97 Martingue Circle U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 🂢 No Specify: Specify: White. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Baltimore Gas & Elementary/Secondary (0-12) College (1-4or 5+) Electrical Designer Electric 10th Grade and Mental Hygie 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental Georgia Fenwick Joseph Arthur Grisbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or othar traum Mr. James Grisbach 2823 Bauernwood Ave., Parkville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem'l 3/13/2004 Timonium, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21, Signature of Funeral Service Licensee 9705 Becair Rd., Bactimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit certificate be executed Due to (or as a consequence of): attending physicien 68760 Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🕅 No certificate 1 Yes 1 Tyes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only only Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 3 DOA his funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ō Hoapital within 24 hours To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) the 29c. License number 29b. Signature and title of certifier 0 0 D3066 5601 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Dr. Sireesh Tripuraneni 32. Registra Signature 31. Date filed (Month, Day, Year) State

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Registrar

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		1 - For State Registrar	State of Ma	aryland	I / Dep <i>Ce</i>	artment of F	lealth an <i>Death</i>	d Mental H	ygien Reg. N	^e 200	07952
Physicia /Medica	-	1. Decedent's Name (First, Middle, Las Patricia Mary Gei	t) ger					2. Date of D Month		ay Year	
Examine Funeral Director		218-38-4366	1th of	Bei e (In yrs. la.	AIC st birthday) Yrs.	BC A III	If Under 24		irth Dey, Year	C. County of Dea	
yland		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
he Mar	Director	Md. Harford	<u> </u>	Da	rling				,		1 ☐ Yes 21X No
h with t	al Dis	10e. Street and Number 3722 Love Road				10f. Zip Code	034			itizen of What C nited St	
1036 ours after death with the Marylan rat, or items 23a or 28e-f show Exertiner must be notified at	Dy runeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2\(\bar{\text{Y}}\) N If Yes, Give Year or Dates:			Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? n, Mexican, Pi Specify:	(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Am Black, Wh Specify: To	
72 hc	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation	T)	16a. Dece (Give life. homem	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of	working		Kind of Business	
Iryland 212: should be filed within the Mental Hygiene. Id Mental Hygiene. In marked other than marked other than marked other than marked other than the Mental County.	2	11 years 17. Father's Name (First, Middle, Last)			nomen	laker	18. Mother's I	Name (First, Middle			
should be nd Mental marked cumatic eve	2	Jess Stevens						e McNicho			
	ï	19a. Informant's Name/Relationship (T	, ,			ng Address <i>(Street a</i> Love Roa					Zip Code)
U 00		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 1 `4 □ Donation 5 □ Other (Specify,	Removal from State		ce of Disponetery, crer	esition (Name of matory or other place of Faith	9)	Date /9/2004	20c. L	ocation - City or	
Baltime permit. Peg Department Important: I any injury o		21. Signature of Funeral Service Licens	R. Da	ind		Schimunek 610 W. Ma	cPhail	Road, Be	iA L		Inc. 21014
Physician /Medical Examiner	3	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	THE CAUSE OF BACK IN	n O N I	nce of):	er the mode of dying	j, such as card	fiac or respiratory a	arrest,		Approximate Interval Between Poset and Death Will & Ken
ficate be executed physicien and is the burial-transit		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequer	nce of):						
The law requires that the death certifule has been signed by the attending agge 2 should be detached for use a completed by Physician/Me		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year
	î í	Part II. Other significant conditions co	ntributing to death bu	t not resultii	ng in the ur	iderlying cause give	n in Part I.	5.4			the cause of death?
VICAL MECONO icien: The law requi sertificate has been s ector, page 2 should Be Completed		DE Was assessed to a street						1 ☐ Yes	psy ormed? 2 \Begin{align*} No	prior to death?	topsy findings available completion of cause of 2 No
hysicier hysicier his certif I director		25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	lospital:	it 2□ER	/Outpatient	04-		eath (Check only of Home 5 Resi		6 ∏Other (Sne	nifu)
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28	b. Time of Injury	28c. Injury Wark' M 1 🗆 Y	at	28d. Describe			,
pitel or Atl urs after d arel Direct illed in by I		3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	(Specify)				City or 1 or	wn, State)	ral Route Number,
he Hosp in 24 hou he Fune pletely fil		29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state		dge, death and/or inv	occurred at the time estigation, in my opi	e, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To the comp		29b. Signature and title of certifier	5			29c. License	number 1452		29d. Dat	e signed (Mont)	n, Day, Year)
4	3	30. Name and address of person who co		ath (Item 23	a) (Type, F	Print)	1	M.)	/	11011	,
State Registrar	3	B1. Date filed (Month, Day, Year) 1 2	2004 ^{22. Registrar}	's Signature	A J	29c. License	() In .	enuy/vi	14	alvig	

07953 State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 = State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 2004 Month **Physician** 9 10:45 p M March Richard K. Greenbank /Medical 4c. County of Death 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Linthicum Chesapeake Hospice House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 XM 2□ F Hours Apr. 23,1924 578-24-6498 Washington DC Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10b. County or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director Anne Arundel Annapolis 10a, Citizen of Whet Country? 10f. Zip Code 10e. Street and Number 21401 USA or Iteme 23a 1 C Compromise Street filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1941-45 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ Medicine Psychiatrist other treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othnerly injury or other treumatic event, 90ce. 17. Father's Name (First, Middle, Last) Be Zoda Kelly George Greenbank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sondra J. Greenbank (Wife) 1 C Compromise Street, Annapolis, MD 21401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/12/2004 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (arcinem /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760. physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? jo 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No page 2 □ No 1 Yes 1 Yes or Attending Physician: rector. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) House Hospital: 1 ☐ Inpatient 1 Yes 2 XNo 2 ER/Outpatient 3□ DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Á 4 | Homicide filled the Hospitel 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)4529 aine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 104 Ridgely Avenue, Annapolis, MD 21401 Elaine Arata, MD, 31. Date filed (Month P. Ydar 2 2004 32. Régistrar's Signature State 2662 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 1 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year P_{M} **Physician** 4:39 MAR 6 2004 VERNON EUGENE GIBSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 29,1942 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1√2 M 2□ F Days Hours 402-58-3964 Kentucky Director Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Anne Arundel Deale Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 712 Kingfisher Road 20751 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? ¹XXYes 2 □ No !f Yes, Give Year or Dates: 1960-80 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. a filed within 72 hours after all Hygiene.

I Hygiene.

other than "naturel; or Ite. 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White ğ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inventory Manager Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be iment of Health and Mental I tant: If Item 27 Is marked o Orville Roswell Gibson Alice Ann Jone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cecil Ann Gibson (Wife) 712 Kingfisher Road, Deale, MD 20751 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Important: If It eny injury or o once. 1 Burial 2 Cremation 3 Removal from State *4 □Donation 5 □ Other (Specify) Maryland Vet. Cem. 3/11/2004 Cheltenham, MD 21. Signature of Funeral Service Ocensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. MD21401 12 Ridgely Avenue, Annapolis, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAC ARRHYTHMIA resulting in death) /Medical Due to (or as a consequence of): 14.74 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-I Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death bull not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 autopsy performed? certificate 1X Yes 2 No To the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpalient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo 2 ER/OutpatienI 3 DOA this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; Alter Injury 1 Natural 5 Pending investigation within 24 hours after deau...
To the Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MAI2 09, 2004 MD 0101235128 (VA) NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 AUDREY G. BOLANOWSKI LT MC USN nature 32. Registrar's Sign 31. Date file (Adath, Pay Year) State Registrar

		1 - For State Registrar 1. Decedeni's Name (First, Middle, Lasi	State of Man	yland / Dep <i>Ce</i>	artment rtificate	of H	ealth a Death	and M	ental Hy	Reg. No) 4	0795
Physic /Med Exami	ical	Joan F. Gibso 4a. Fecility Name (If not institution, give 4942 Brightleaf	Street and number)			own, or	Location o	of Death	March	9, Da	2004 County of		3. Time of Death 2:25PM
Funeral Director				n yrs. last birthday, 9 Yrs.		Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Oct. 23	3, 193	34	Birthple County Mary.	ece (State or Forei o) Land
the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD Baltimo 10e. Street and Number		Oc. City, Town or L	ore	2 and a				10- 6			d. Inside City Limi
th with 1	ai Dir	4942 Brightleaf	Court		10f. Zip (1237	7				S.A.	al Counti	ry?
72 hours after death with the Maryland natural', or Items 23a or 28a-1 show alcal Examinat roust be notified at	by Funer	11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 Tho If Yes, Give Year or Dates:	or in U.S. 13.	Was Decede If Yes, speci 1 Yes 2		spanic Origin, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)	>-	14. Race Black, Specify:	America White, e	tc.
within ene. then	Completed by Funeral Director	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use OMEMak	done di retired)	tion uring most	of working	ng	16b. K	of Busi		ustry
	To Be (17. Father's Name (First, Middle, Last) Herbert W. Brazi					Nel	lie	McGee				
ges 1 and 2 should it of Health and Mer if item 27 Is marks or other traumatic		19a. Informant's Name/Relationship (T) Patrick W. Gibson	- Husband	4942	Brigh	tle		urt	Route Numb Baltimo				
permit. Pages 1 ar Department of Hea Important: If item: any injury or other once.		20a. Method of Disposition 1 National 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	Cob. Place of Disposition Commetery, creating Commeters (Control Control of Fai	th (em. 3	3/13/		Bal	timor	e, M	m, Slate Maryland	
Depar Impor		21. Signature of Funeral Service Licens	# Heather		Name and	Addres: arfc	ord Ro	Leor oad E	nard J. Baltimo	Ruc re,	k, Ir Maryl	nc. and	21214
Pnysician /Medical		23a. Part1. Enter the disease, or compishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ications Ihat caused the ne cause on each line. a	statue	er the mode	of dying	, such as d	cardiac or	r respiratory a	rrest,		J	Approximate nterval Between Onset and Death
cate be executed working the burial-transit to burial-transit to be the control of the burial-transit to be the burial-transit to be the burial-transit to be the control of the burial-transit to be the control of the burial-transit to be the control of the cont	ical Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co										
Attending Physicien: The law requires that the death certifica r death. r death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pred Other (spec		7-50			4	23d. Date of Month		ay Year
w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	nderlying cai	ise giver	n in Part I.		23e. Did to		1-		cause of death?
n: The law requires t loate has been signe r, page 2 should be o	Completed	J							24a. Was autop perfo 1 Yes		prio	r to comp th?	y findings availab pletion of cause of No
ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital:	2 ER/Outpatien	J 3□ DOA	Other			(Check only o		Other /	(Specify)	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director; After this certificate his completely filled in by the funeral director, page		27. Manner of Dealh 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Dale of Injury (Month, Day Ye	28b. Time of Injury	286 M	injury a Work? 1 □ Ye	at	28	8d. Describe h				
To the Hospital or Attendin 24 hours after death within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, elc. (S	ipecify)	·				City or Tou	m, State)			Route Number,
To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Examination	sician: To the best of more: On the basis of exa and manner stated.	y knowledge, death amination and/or inv	occurred at restigation, in	the time my opi	, date and nion, death	place, ar occurred	nd due to the d d at the time, d	cause(s) date and	and manne place, and	er as state due to th	ed. ne cause(s)
To the within To the to the comp	×	29b. Signature and title of certifier	1 Hal		29c.	License		396	,	29d. Date	signed (A	fonth, Da	y, Year) OU K
12		30. Name and address of person who co	hn, 5001	hechi	Prigt)	n E	3/mQ	B	a Hiv	ine	M	d.	21239
Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's :	Signature	Per 1		0 1 -				,		

ORIGINAL

	ııuç	thes Please 1 - For State Registrar	State of M		Depar	tment o	n k. Ensu of Health a of Death		ental Hyg			0795
		Decedent's Name (First, Middle, Las	t)						2. Date of Dea			3. Time of Death
Physic		Tamaria		H	lughe	s			Month March (07, Day	2004 Year	0115 A
/Medi Exami		4a. Facility Name (If not institution, give	street and number)				vn, or Location of	Death		4c. C	County of Deat	
		Howard County Poli	ce Headquar	ters		Ellic	ott City			F	bward	
Funeral		5. Social Security Number 6. Se		ge (In yrs. last bi		If Under 1 Y	ear If Under 2 ays Hours	4 Hrs.	B. Date of Birti (Month, Day	h v. Year)	9. Birtl	nplace (State or Fore
Director		215-88-7782	☐M 21XF	36	Yrs.	INION(III)	ays Hours		9-16-6		Md	·
pu ,	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	un or Loca	ution.						10d. Inside City Limi
anyla ehov	<u>-</u>	10a. State 10b. County		100. 0119, 101	WIT OF LOCA	tion .						Yes 201
Ba-1	ctc	Md NA	_	<u>F</u>	Balti					40 - 02		
ij) ti	Funeral Director	10e. Street and Number				10f. Zip Cod				-	en of What Co	untry ?
23a	a	2255½ Pentland D					234		- N	US		
tame tame	Tue	11. Marital Status	12. Was Decedent Armed Forces	?	13. Wa	as Decedent Yes, specify (of Hi <i>s</i> panic Orig Cuban, Mexican,	Puerto R	rry Yes or No- ican, etc.)	. 14	 Race - Ame Black, White 	
72 hours after deeth with the Maryland natural', or Itams 23a or 28a-1 show dical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 又 Divorced	1 ☐ Yes 2 ☑ If Yes, Give X Year or Dates:	No	1 [Yes 2	No Specify:			5	Specify: Bla	ack
hour	d b	15. Decedent's Ed			Decade	nt's Usual O	ccupation			16b King	d of Business/	
n 72	Completed	(Specify only highest gra-	de completed)		(Give kii	nd of work di	one during most	of working	7	100. 1411	a or 20011100a	
within than	l m	Elementary/Secondary (0-12)	College (1-4or	5+)	Cross	sing G	uard			Balt	imore	City
Hyginther ther		17. Father's Name (First, Middle, Last)			04 000			's Name	First, Middle,			
d be	Be C	John	ጥι	ırner			Suc	ddie		Mae	Bo	nner
d Me	2	19a. Informant's Name/Relationship (7			b. Mailing	Address (St	reet and Number					
permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Licen	Valler.	July Badash Do	Ma	arch F	ddress of Facility '.H. East	t	1101 E	. No	e, Md. rth Ave	21202
Pnysician /Medical Examiner		In children disease, or component of the	a. A Sphy	line.	blunt	r	a injuri					Interval Between Onset and Death
id ansit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bDue to (or as	s a consequence	of):							
be exec ician an burial-tr	Exa	that initiated events resulting in death) Last	Due to (or as	s a consequence	of):							
g phy as the	edic											
death cer e attendir id for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ※Unknown		e of pregnancy 2 Petal death at time of death		ctopic pregn Other (specif				23	3d. Date of deli Month	very Day Year
by tac	b	Part II. Other significant conditions of	ontributing to death	but not resulting	in the und	lerlying caus	e given in Part I.		23e. Did to		,	the cause of death?
S C 0	1 2								24a. Was autop perfor	rmed?	24b. Were au prior to death?	topsy findings availal completion of cause of 2 No
e law requires has been signi ge 2 should be	omple						ne Diego	of Death	Check only o		74.50	
The law requires ete has been signi page 2 should be	e Completed	25. Was case referred to medical					20. Place					
The law requires ete has been sign page 2 should be	o Be	25. Was case referred to medical examiner? Total No. 12	Hospital: 1 ☐ Inpat	ient 2□ER/O	outpatient	3□ DOA	0#		e 5 Resid	lence 🖔	⊠ Other (Spec	ity) At scene
Physician: The law requires this certificete has been signiral director, page 2 should be	To Be	examiner? >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	28a. Date of Inj	ury 28b.	Time of		Other: 4 Nur	sing Hom	e 5 🗌 Resid			aty) At scene
ing Physician: The law requires After this certificete has been signi uneral director, page 2 should be	To Be	examiner? \$\infty \text{X}\text{Yes} 2 \subseteq \text{No} 27. Manner of Death 1 \subseteq \text{Natural} 5 \subseteq \text{Pending} 2 \subseteq \text{Accident} investigation	28a. Date of Inj (Month, D	ury 28b. 2 004 :	Time of Injury	28c.	Other: 4 Nur Injury at Work? 1 Yes 2 N	rsing Hom	ad. Describe h	now injury was	occurred a ssav	te cl
Physician: The law requires this certificete has been sign al director, page 2 should be	o Be	examiner? Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D	ury 28b.	Time of Injury	28c.	Other: 4 Nur Injury at Work? 1 Yes 2 N	rsing Hom	ad. Describe h	now injury	occurred occurred Number or Ru	

To the Hospit within 24 hours To the Funers completely fills

29a. Certifier
(Check only one)
29b. Signature and title of certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Joshu 3 Meenherg Ma

30. Name and address of pers of who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

March δ , 2004

Tasha Z Givenberg M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 17 Rev 1/2001

MAR 1 2 2004

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month March 11,2004 12:40^AM **Physician** Hughes, Sr. Walter John /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Days Hours Min. (Month, Day, Year)

Dec. 23, 1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊋M 2□F Yrs. 213 32 3922 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 1511 Barkley Avenue 21221 Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1≦Yes 2☐No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ White 3 ☐ Widowed 4X Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Corp. Heater Coke Ovens 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any ijury or other traumatic event 2008: 17. Father's Name (First, Middle, Last) Staudenmeyer William Hughes Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas Hughes (son) 1136 E. Riverside Avenue Essex Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc 3/11/2004 Baltimore Maryland 22. Name and Address of Facility 23a. F. rt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so ci, or heart failure. List pnly one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. 21. Scripture of Furieral Service Licens Bruzdzinski Funeral home PA 1407 Old Eastern AVenue Essex Maryland 21221 Approximate Interval Between Onset and Death **Physician** Years /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2/2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 58303 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Charles My 6601 N. Charles St Baltimae Mp 21204 31. Date filed (Month, Day, Year) MAR 12 2004 32. Registrar's Signature State Registrar

Hughes, Worker

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ellen Hallock February 29 2004 1445 Rosie /Medical 4c. County of Deeth 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X 79 Dec. 25,1924 Virginia 579-26-5566 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or Itams 23a or 28a-f shot other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Anne Arundel Shady Side 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20764 USA 1270 Steamboat Road death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene Important: If frem 27 is marked other than "natural; or Itan any injury or other traumatic event, the Medical Emminer 2002. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 White Specify: ð 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 12 Bookkeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ross Harvey Poole Effie Trammell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gordon E. Hallock (Son) 1700 Maryland Avenue, Shady Side, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 3/5/2004 Baltimore, MD 21. Signature of Funeral 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or conditioning that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition NEUMONIA Priysician resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 3 Probably 1 ☐ Yes 2 \square No 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No this certificate has 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P/Outpatient 1 Inpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Naturaf 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation or Attend after death Director: 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours at To the Funeral D rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifie Old Solomons Island unlea Ju 22 Registrar's Signature State Registrar

			1 - For State Registrar	State of N	/laryland / D	epartme <i>Certifica</i>	nt of H	ealth D <i>eath</i>	and M	ental Hy	giene Reg. No.	20 0	4 0	796
H		K	Decedent's Name (First, Middle, La	ıst)						2. Date of De	ath			of Death
В	Physic		Carol	Ann	How	ard				Month	Day 6	2004		5 p M
7	/Medi Examir		4a. Fecility Name (If not institution, give	e street and number	or)	4b. Cit	y, Town, or	Location	of Death		4c. C	ounty of De		<u> </u>
			Laurel Regional	Hospital			Laure	<u> 1</u>			Pri	nce (Georges	
	Funeral Director		or occurry manner	Sex 7.7 1 □ M 2 🗓 F	Age (In yrs. last birt	rs. If Und	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Dale of Bir (Month, De	th y, Yeer)	9. E	Birthplece (Stet Country)	e or Foreign
S.	All therein		Usual Residence of Decedent							May 24	, 193) W1	SCORSI	LI
	yland		10a. State 10b. County		10c. City, Town	or Location							10d. Inside	City Limits
	Mar B-f-sl	Director	MD Anne Ar	undel	Od	enton							1 🗆 Y	es 2 No
	or 28	ire	10e. Street and Number			10f. 2	ip Code				10g. Citize	n of What	Country?	
	23a	<u>a</u>	724 Linden Grove	Place, A	Apt. 103		21113	3			U	SA		
21215-0036	be filed within 72 hours after death with the Maryland Ital Hyglene. Id other then "natural", or Items 23a or 28a-f show event, I'm Medical Evarriner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Privorced	12. Was Deceder Armed Force 1 Tyes 2 If Yes, Give Year or Dates	s? Į No	If Yes, sp	edent of Hi ecify Cuba 2 X No	spanic Or n, Mexical Specify:	n, Puerto I	cify Yes or No Rican, etc.)		Black, Wi	nerican Indian, hite, etc. White	'
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2	e filed within al Hygiene. I other then "	Ou	, , , , ,	2		oker					Rea1	Esta	te	
b	al Hygi t other	Be (17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle	Maiden Si	u <i>mam</i> e)		
Va	should be ind Mental I	0	John Charles Gri	ese1				Gra	ce An	n Clea	ry			
Maryland	2 should be and Mental is marked raumstic ever		19a. Informant's Name/Relationship (,		Mailing Addre	ss (Street a	nd Numb	er or Rura	Route Numb	er, City or T	Town, State	Zip Code)	
	and ealth m 27 ner tr		Carol M. Howard	(Daughter				y, S		, MD 2				
ore	ges 1 and 2 should t of Heaith and Men if item 27 is marke or other traumstic		20a. Method of Disposition 1 Burial 2X Cremation 3	Removal from Stat	20b. Place of cemetery	Disposition (N r, crematory o	ame of other place	9)	D	ate	20c. Loca	tion - City of	or Town, Slete	
Ĕ	Pag ment ant: I		'4 □Donation 5 □Other (Special			Cremat	ory		3/10/	2004	Balt	imore	, MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is sny injury or other tra ance.		21. Signature of Funeral Service Lice	See .		22. Name Hard	esty	Fune:	ral H	lome, P Annap	.A.	MD 2	1.401	
ak.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the death. Do n							MD Z	Approxim Interval B	ate
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Renal	Failure	f):							Onset an 2 ye	d Death
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		ner	Sequentially list conditions, it may be a sequentially list conditions, cause. Enter Underlying		s a consequence o	b:								
	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events	c]	
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9	certificate be executed nding physicien and use as the burial-transit	Med	IF FEMALE:											
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O		y Pi	Part II. Other significant conditions of	contributing to death	but not resulting in	the underlying	cause give	n in Part I		23e. Did to	obacco use	contribute	to the cause of	f death?
rds	quires n sign	Q D	Pancreatic Insu	fficiency						101	/es 2 □ I	No 3□F	Probably 4X	X Inknown
Vital Record	> 40 00	Completed	Hepatic Failure							24a. Was	an 2	24b. Were a	autopsy finding	s available
Re	o -C 2	mc d								autop perfo		prior to death?	completion of	
ta	icien: Th certificate rector, pag	Ö	Chronic Obstruc	tive Pulm	onary Dis	ease		26 Place	of Dogth	1 ☐ Yes (Check only o		1 LJ Y6	s 2 No	
	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2XXNo	Hospital: 1 XInna	tient 2 ER/Out	nationt 3 🗆 [OA Othe	-		e 5 Resid		Other (Se	north (
of	g Phy er thi	n: T	27. Manner of Death	28a. Date of In (Month, D		me of	28c. Injury Work	-		8d. Describe			o cny)	
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Vis	Atten r deal ector	ifica	3 Suicide 6 Could not b	28e. Place of I	njury - At home, fari	n, street, facto	ry, office		2	8f. Location (S	Street and N	Vumber or F	Ru <i>ral R</i> oute Nu	mber,
ā	after I Dire	ert	4 🗆 Hottlicide	bullding, (etc. (Specify)					City or Tox	m, State)			
	To the Hospitel or Attentivitin 24 hours after deati To the Funerel Director: completely filled in by the	edical (29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	sysician: To the bes niner: On the basis and manner:	of examination and	death occurre for investigation	at the time n, in my op	e, date an inion, dea	d place, ar th occurre	nd due to the d at the time,	cause(s) and pla	d manner a ace, and du	is stated. ie to the cause	(s)
	To the h within 24 To the F complete	Me	29b. Signature and title of certifier	7/		2	c. License	number			29d. Date s	igned (Mor	th, Day, Year)	
	- 2 - 0		1/hlhl-	zillier	The		D2409	93			3/7	/2004		
	1		30. Name and address of person who	completed cause of	death (Item 23a) (1	ype, Print)					- • •			
	5	Į.	Mark Parkhurst,		ll Sarvis		e, Riv	verda	1e, 1	MD 2073	37			
No.	Sta Registr	1.	31. Date filed (Month, Day, Year) MAR 1 2 200		trar's Signature	A)								
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DHNH 17 Hev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registra Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year HUBBARD **Physician** IARY 2.40AM MARCH /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Northwest Hospital Center Randallstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 □ F 85 Yrs Dec 6 1918 Md Director 215-07-5734 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f shov other traumatic evant, the Madical Examinar must be notified at Md Baltimore Marriottsville 1 ☐ Yes 2 ▼ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21104 USA 3818 Wards Chapel Road Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Year or Dates: 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be W. Richard Williams Eleanora Dauman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3820 Wards Chapel Rd., Marriottsville Md 2110 Date 20c. Location - City or Town, State Mrs. Sharon Jackson (Daughter) Md 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ott ance. 1 Burial 2 Cremation 3 Removal from State Sykesville, Md Lake View Mem. Park 3/6/04 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL 21. Signature of Puneral Service Licensee Mar P.O. Box 195 Sykesville, Ma 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. METASTATIC Pnysician BREHST MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Completed by Physician/Medical attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⊠Unknown INTRA ABDOMINAL ABSCESS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2DNO 1☐ Yes 2 (**∑** No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ANatural 1 ☐Yes 2 ☐No 24 hours after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 ů, 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 1)54288 *K Wangenaza March 2nd 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORALWEST HUSPITAL MEDICAL CENTER RANGHRADIN KAMINIWAMY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 2 2004 Busins Registrar

			1 - For State Registrar		aryland / Depa	artment of H rtificate of L		lental Hygie	4	004	0796
	Physici /Medi		TULIA IACKSON Month Day Year City								3. Time of Death
	Examir		4a. Facility Name (If not institution, 9	venue		4b. City, Town, or	4c. County of Death N/A				
£	Funeral Director		5. Social Security Number 217-24-6335 Usual Residence of Decedent	. Sex 7. Aq 1□ M 2⊡ F	ge (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Sep 2,]		9. Birthpled Country Mary	ce (State or Foreign v) Land
	e Maryland a-f show	ctor	10a. State 10b. County MD N/A		10c. City, Town or Lo					10d	I. Inside City Limits
	ath with th	Funeral Director	10e. Street and Number 3608 Calloway A		10f. Zip Code 21215		Citizen of W	,			
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23e or 28e-f show event, it a Madical Exemirer must be notified at	b	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2□ No Specify: Specify: B1					.	
	d within 72 h giene. er then "netu i the Medical.	Completed	(Specify only highest grade completed) (Giv			lent's Usual Occupa kind of work done d DO NOT use retired)	o. Kind of Business/Industry Intertainment				
		To Be (17. Father's Name (First, Middle, La Clinton Savage 19a. Informant's Name/Relationship	2	10- 14-7		Lillie	Bowie			
	1 and 2 s Health ar om 27 is ther trau		Ms. Avona Seymo 20a Method of Disposition 1 □ Burial 2 ☑ Cremation 3	re/Daughte		Dolfield	Avenue,			21215	
Baltim	permit. Pages Department of the Important: If Ite any injury or of		*4 □ Donation 5 □ Other (Special Service Lice)	cify)	Chesapea	ake Cremat Name and Address Cremation	ory	Mar 16 2004 Be eral Alte es Drive	eltsvi rnativ	es	
8760	physician and purial-transit ine burial-transit	dicai Examiner	International class of sach line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. The same large of the final disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								oproximate terval Between nset and Death
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						23d. Date of delivery Month Day	
ords, P.	w requires that been signed b should be deta	۵	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.						Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown		
Vital Records,	en: The law r tificate has be tor. page 2 sh	e Completed	25. Was case referred to medical	T			20.2	24a. Was an autopsy performed 1 Yes 2 1	? dea	or to comple ath?	findings available etion of cause of
Division of Vil	hysi his c	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigating investigating investigating the Homicide determine	28e. Place of Inju	y Year) 28b. Time of Injury	3 DOA Other: 28c. Injury a Work? M 1 Ye	ut 2	Residence 8d. Describe how in 8f. Location (Street	jury occurred	j	oute Number,
בֿ	Hospitel or 24 hours aft 5 Funeral Di stely filled in	edical Cer	29a. Certifier (Check only one) 29a. Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
•	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year)								Year)
	6		1/0	ind 5	710 MAG	MSH A	VE. B	SALT. MS	210	25	
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State of Maryland / Department of Health and Mental Hygiene 2 = State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month **Physician** narro NNIS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner DITA If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (W yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. Hours ¥ M 2 □ F Months Yrs Director 218-90-8613 39 6-15-64 Md. Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 □ No Directo Md. Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 633 N. Avondale Rd. 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 (☑Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status hours after Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Truck Driver Cotton Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) t. Peges 1 and 2 snows of intent of Health and Mental Hyprant: if Item 27 is marked off Be Julius Hinton Jones Teresa Jones 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avondale Rd., Dundalk, Md. 21222
(Name of Date 20c. Location - City or Town, State Teresa J. Martin 663 N. Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Bonation 5 ☐ Other (Specify) permit. Pege Department of Important: If any injury or once. Garrison Forest Vet. ! 3-15-04 Owings Mills, Md. 21. Fignature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 ilese March F.H. East 1101 E. North Ave 23a. a./1. Enter the disease, or complications that caused the sock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) tabou MEDa Physician /Medical Due to (or as a consequence of) Examiner / wil Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Thab do muo.

Due to (or as a consequence of): physician Physician/Medical the use as I IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 99 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 X No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 213 No 2V No 1 ☐ Yes certificate Vital Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient TYes 20 No 3 DOA Certification: To this of 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Hospitel or Attending Division Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 701 RES-000 MARCH 10, 2004 30. Name and address of pirson o completed cause of death (Item 23a) (Type, Print) HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287-9906 GARRETT LASALLE, THE TOHNS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 10:14 AM MARY A. JOHNSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 11833 Franklinville Road Upper Falls Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M XX 215-01-2941 Director 95 09/05/1908 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County in than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Upper Falls 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 11833 Franklinville Road 21156 Funerai Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Candy Maker Candy Company le marked other 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 William Luddy Elizabeth Lyston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11833 Franklinville Road - Upper Falls, MD Mary E. List (daughter) If Itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Its any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 03/10/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Lassahn Funeral Home
7401 Belair Rd. Baltimore, hite 21236 Approximate Interval Between Onset and Death 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Rosk resulting in death) Due to (or as a consequence of): /Medical **Examiner** 1-20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physicien by Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy 1 Live birth 2 | Fetal death Year jo Month Dav 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 2□ No certificate 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Certification; To 2 T ER/Outpatient this 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the 3 Suicide 4 Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P RUS 31. Date filed (Mind Pay Year) 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** INABHINGTON LINGERFELT GEOZGE MARCH 2004 8 16=08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARROND BELAIR UPPER CHEJAPEAKE MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) July 30, 1928 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 € M 2 ☐ F North Carolina Yrs. Director 243-34-5268 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examples in the notified at Yes 2 No Bel Air Harford Director Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21014 300I Canterbury Road by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 ☐ No 1946 If Yes, Give Year or Dates: to 1949 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3altimore, Maryland 21215-0036 Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) manufacturing Elementary/Secondary (0-12) College (1-4or 5+) machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William O. Lingerfelt Ella West 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $3001\ Canterbury\ Road,\ Bel\ Air,\ MD\ 21014$ 19a, Informant's Name/Relationship (Type, Print) Mabel Lingerfelt/wife Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ō = 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. Gardens of Faith Cem. 3/11/04 ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. land. M 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INFAZCT ALUTE INFERIOR - POSTURIOR WALL /Medical Due to (or as a consequence of): Examiner A 500 D Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Division of Vital Records, P.O. Box 6876 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SIP CORONARY ARTERY BYPASS SURGERY Completed 24b. Were autopsy findings available prior to completion of cause of death? AND colostomy for ruphrel 24a. Was an L HEMILOLEZIUMY autopsy performed? 2 40 discore (3) COP 2 No 1 Yes DIVERLENICY 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nanpatient 2 ER/Outpatient 3 DOA P 1 XYes 2 ☐ No 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 塔 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fo the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 021809 DME MANCH 8, 2004 ganish 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2336 YO LIC NO 5 PRASHUMO 1, MON, UM MO book 31. Date filed (Month Par Year) 2 State

DHMH 17 Rev 1/2001

Registrar

		Registrar 1. Decedent's Name (First, Middle, Lat			nd / Depa					2. Date of D	eath			0.79
Physici		Elsie May Leveng	-							March	8, ^{Day}	04	Year	11:45
/Medic Examir		4a. Fecility Name (If not institution, give street and number) Genesis Elder Care - Hamilton			4b. City, Town, or Location of Death Baltimore City 4c. County of Death n/a									
Funeral Director		5. Social Security Number 6. S 216-22-4205		Age (In yrs 87	s. last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	24 Hrs. Min.	8. Date of B (Month, D Dec.	inth law Year) 9	16	9. Birthp Pen	olace (State or F irry) nsylvan
3		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation							1	0d. Inside City I
-f eho	ğ	Md. n/a			Baltim	ore								1☐XYes 2
and Manial Hygiene. Ie marked other than "natural", or items 23a or 28a-f ehow eumstic event, Ibs Medical Exant act must be notifiled at	Jirec	10e. Street and Number 4612 Frankford Avenue				10f. Zip		226			_		What Cour	
	rai					Was Dasa		206	rin2 (Cno	aifu Voc or N	United States 14. Race - American Indian,			
	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1 ☐ Yes 2¾ If Yes, Give Year or Dates	s?] No	į.	was Dece If Yes, spe			, Puerto	ecify Yes or N Rican, etc.)			ck, White,	
	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Dece (Give life.	dent's Usu kind of wo	al Occupa	ation furing most	of worki	ng	16b. Kin	d of Bu	usiness/In	dustry
than the	mpi	Elementary/Secondary (0·12) College (1-4or 5+) homema							own home					
Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last)						18. Mother	r's Name	(First, Middl	e, Maiden S	uman	ne)	
Mental rrked rtc ev	To B	Frank E. Moore						Bes	ssie	C. Mal	Llory			
le ma le ma reuma	·	19a. Informant's Name/Relationship (-				I Route Num				Code)
Health em 27 ther ti		Scott M. Levengo 20a. Method of Disposition	od/son	20b.	Place of Dispo	sition (Na	me of			el Air,			015 City or To	own, State
Department of Health and Menta Important: If item 27 le marked any injury or other treumatic evente.		1 StBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	1)	• Hi	cemetery, crei ghview	matory or o Mem.	Gdns		3/12/		Fall	sto	on, M	d.
Depart Import any in		21. Pure of Funeral Service Loer 23a. Part 1. Enter the disease, or com shock, or heart failure. List only	11111		22	2. Name ar Sch 61(nd Addres nimur) W.	is of Facility tek Fu MacPh	nera ail	al Home	e of E	el ir	Air,	Inc. 21014 Approximate
/sician and /sician and /sician e privial-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a Du	is a conse	MER duence of):	'S	Dis	FAS	E					
by the attending phy ached for use as the	by Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 O No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fel at time of	tal death 3	⊒Ectopic p ⊒ Other <i>(sp</i>					23		te of delive	ery Day Yea
signed by d be detac	d by Ph	Part II. Other significant conditions of	ontributing to death	but not re	sulting in the u	nderlying	cause give	en in Part I.			tobacco us	-		ne cause of dea ably 4 🗆 Uni
within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Completed									peri	s an opsy formed2 2 No		Were auto prior to cor death? 1 Yes	psy findings ava mpletion of caus
	Be	25. Was case referred to medical examiner?	Ha saitali				Othe	-		(Check only				
	on: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	Hospital: 1 ☐ Inpa 28a. Date of In (Month, L	ijury	□ ER/Outpatier 28b. Time o Injury	f	28c. Injun Work	at	1	me 5 ☐ Res 28d. Describe				v)
	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined					28f. Location (Street and Number or Rural Route Number City or Town, State)							
24 hours Funerel etely filled	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number							ne, date and pinion, deat	d place, a	and due to the ed at the time	e cause(s) a , date and p	nd ma	anner as si and due to	ated. the cause(s)
within To the	Me	29b. Signature and title of certifier					c. License				29d. Date signed (Month, Day, Year)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 07967 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year JOHN. **EDWARD** LAWRENCE, 5.38PM JR. 03 08 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BAYVIEW JOHNS HOPKINS BALTIMORE
If Under 1 Year | If Under 24 Hrs. N/A8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 ☑ M 2 ☐ F 146-34-3289 61 2-25-1943 NJ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 N. KENWOOD AVENUE 21205 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced **BLACK** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CHEF COLLEGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ETHEL SCOTT JOHN EDWARD LAWRENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 N. KENWOOD AVE. BALTIMORE, MARYLAND 21205 MADELINE LAWRENCE/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

^ 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 3-10-2004 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. a 1701-31 LAURENS ST. BALTIMORE, MD 21217 ames 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition heat LONOWONY resulting in death) Due to (or as a consequence of): Varlare Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last evelorovacua accio Due to (or as a consequence of): 1 of perterne IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 Yes 2 No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 2 X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29c. License number tle of certifier 29d. Date signed (Month, Day, Year) 29b. Signature and 0 0055171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEBASTIAN DOIM 3033 CASTERN AVENUE BALTMURE 31. Date filed (Month, Pay, Year). 32. Registrar's Signature

State Registrar

Physician

/Medical

Examiner

Funeral

Director

r than "netural", or iteme 23a or 28a-f ehow the Medical Examiner coust be restified at

and Mental Hygiene.

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permit. Page Department of Importent: If eny injury or once.

Physician

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Examiner

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page 2 certificate

filled in by the funeral director.

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The law requires that the death certificate be executed

Division of Vital Records, P.O.

To the Hospital or Attending Physician:

Examiner

Physician/Medical

Completed by

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Certification: To

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Pages 1 and 2 should be

or other traumatic event,

Funeral Director

Completed by

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

2004

STATE SOL

inside!

Œ		•	1 - For Amend Item 26 per	State of Marylan Verb., G829,03/12	nd / Departme 2/04dhb <i>Certifica</i>	ent of Health and ate of Death	Mental Hygier	2004 079	68	
	Physici /Medic	al	Decedent's Name (First, Middle, Last) AR N 4a. Facility Name (If not institution, give s		EAKE	SK. ty, Town, or Location of Deat	March 1,	2004 9:45 4c. County of Death		
	Examin Funeral	er	1763 Homestead Str 5. Social Security Number 6. Sex		last birthday) If Und	altimore der 1 Year If Under 24 Hrs	8. Date of Birth	9. Birtholece (State of	or Foreign	
	Director		Usual Residence of Decedent	M 20 F 50	O Yrs. Month	S Days Hours Min.	Month, Days Yea	923 IVIAREY CA	AND	
Baltimore, Maryland 21215-0036	e Marylar ta-f ehow	ctor	MD 10b. County	10c. Ci	BACTI M				zity Limits s 2 □ No	
	death with the Maryland me 23a or 28a-f ehow rintal be notified at	Funeral Director	1763 Homes		LEET	Zip Code 2/2/8	7	Citizen of What Country?		
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. item 27 is marked other than "natural", or itame 23s or 28s-f show other traumatic event, its Medical Exameratinal Les colling at	by	11. Marital Status 1 Never Married 1 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Tyes 2 PNo If Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 22 No Specify:		14. Race - American Indian, Black, White, etc. Specify: DLACK	/	
	id within 72 h giene. er than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	cation completed) College (1-4or 5+)	life. DO NOT	work done during most of wo use retired) DERVISOR	rking	Kind of Business/Industry NDUSTRIAL	-	
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	and 2 sho ealth and m 27 Is m		PAULEHE LEAK	E/WIFE	3436	ess (Street and Number or Ri Wood Stock	LAVE. BA	aimore, MO	21213	
	nit. Pege artment o ortant: If injury or in		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 3 ☐ Cremation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	emoval from State	Place of Disposition (Nemetery, crematory of EEN/MOUNT (22. Name	ALEMATICAL 3 and Address of facility C	14/04 BARREMATIONS	Location - City or Town, State CTIMORE MARY SERVICES	LAND	
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of Vital Records, P.O. Box 68760,	Physician /Medical Examiner physicien and p	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	querica of):	rdiovascular	Disease	Onset and	Deall	
	ne death certific the attending p thed for use as	Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 Ectopic		23d. Date of delivery Month Day			
	uires that the signed by Id be detacted		Part II. Other significent conditions con	tributing to death but not res		id tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown				
				24a. Was an autopsy performed?	prior to completion of cause of death? No 1 Yes 24 No					
f Vita	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 12 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient 3	Othor	eath (Check only one) Home 5 ☐ Residence 6 ⊠Other (Specify) Scene			
ion of	ding h. Alte tune	edical Certification;	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred		
Division	or A		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fact fy)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely tilled in by			sician: To the best of my known and the basis of examinations and manner stated.				(s) and manner as stated.ind place, and due to the cause(s)	s)	
		Me	29b. Signature and title of certifier		2	29c. License number	29d. Date signed (Month, Day, Year)			
			30. Name and address of person who con	moleted cause of death (tter	n 23a) (Type Print)	O.C.M.E.	Marc	h 2, 2004		
_			LING LI. N	1.0	11	l1 Penn Street	t, Baltimor	e, Maryland 212	201	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 2 200	32 Registrar's Signa	ature			-		

			1 - For State Registrar	State of Maryla	nd / Depa	artment of He	ealth and Me Death	ental Hygie	ene 2004	07969
			Degedent's Name (First, Middle, La	st)		/		2. Date of Death		3. Time of Death
	Physici		Commo			Lane	2	MARCH	7 2004	13:45 M
	/Medio Examin		4e. Fecility Name (If not institution, giv	e street and number)		4b. City, Town, or I	Location of Death	175-6-1	4c. County of Deet	
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	Funeral		5. Social Security Number 6. S		. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birti	hplece (State or Foreign untry)
П	Director		214-64-6217	XM 2□F 38	Yrs.	Months Days	Hours Min.	8-16-65	Md.	unitry)
	D.		Usual Residence of Decedent							
	how	_	10a. State 10b. County		ity, Town or Le					10d. fnside City Limits 1 Yes 2 □ No
	Ba-f	ct	Md. Talk	oot	Eastor	<u>1</u>				
	or 24	Director	10e. Street and Number			10f. Zip Code 21601		10g	. Citizen of What Co USA	untry?
	be filed within 72 hours after death with the Maryland lat Hyglene. d other than "neturel", or Iteme 23e or 28e-f show event, the Midfield Examiner mast he modified at	rai	107 Meadow Dr.	Apt. 503						
	tsme	Funerai	11. Maritaf Status	12. Was Decedent Ever in Armed Forces?	J.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	
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ē,	E E E		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place	Da		c. Location - City or	Town, State
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Baltimore,			21. Signature of Funeral Service Licer			2. Name and Address			1-7	
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89	tificate ig phys as the	edi								
ŏ	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		Ectopic pregnancy			23d. Date of deli	
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ta		0	25. Was case referred to medical				26. Place of Death		1.00	20.00
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Division of	g Ph er th eral	n; T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury Work	at 28	3d. Describe how	injury occurred	
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifying Pt	nysician: To the best of my kr	nowledge, deat	h occurred at the time	e, date and place, ar	nd due to the caus	se(s) and manner as	stated.
	the H in 24 the F	Medicai	one)	and manner stated.						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	2	29b. Signature and title of certifier	0.1		29c. License	number	29d	Date signed (Month	, Day, Year)
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	\		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,	Print)	/	(A	, Bolt	inge, was
	\		Loud A. Melack	MD The John	Hopkins	Hespita/	(00 North	woke S	toot Man	iking alas!
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	Regist	ar	MAR 1 2 200	14 Not The Barrens	101	Apountar	/			

				1 - For Registrar	State of Maryla	and / Depa	artment of H	lealth and M Death	lental Hygier		07970
				1. Decedent's Name (First, Middle, La	ast)				2. Date of Death		3. Time of Death
1	1	Physic /Medi Examir	cal	Cynthia 4a. Facility Name (If not institution, gi	Denise ve street and number)	Lambe		Location of Death	March 9,	Day Yeer 2004 4c. County of Death	2:50 pm
		Funeral Director				rs. last birthday) Yrs.	Baltimon If Under 1 Year Months Days	Ce City If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea		place (State or Foreign
		pu a		Usual Residence of Decedent 10a. State 10b. County		City, Town or Loc	cation		ADITI 17	, 1900 Ma.	10d. Inside City Limits
		ours after death with the Maryland 'al', or items 23e or 28e-f ahow Examiner mast be notified at	Director	Maryland Baltime	ore Es	ssex	10f. Zip Code		100	Citizen of What Cou	1 ☐ Yes 2 🛣 No
		With Se or	ā								
		Jeath	era	35 Clipper Road 11. Marital Status	12. Was Decedent Ever in	U.S. 13. V	21221 Vas Decedent of Hi	spanic Origin? (Spe	cify Yes or No-	S. A.	ican Indian.
	36	72 hours after death w "naturel", or items 23a colon Examiner met	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	l lf	Yes, specify Cubar ☐ Yes 2 ☐ No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	Rican, etc.)	Black, White	, etc.
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3/5	121	within nne. Ihan	m	Elementary/Secondary (0-12)	College (1-4or 5+))			
316	d 21	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than 'any injury or other traumatic event, Ite Ma. 2006.		17. Father's Name (First, Middle, Lasi	t)	Homem	aker	18. Mother's Name	(First, Middle, Maid	VN HOME	
0,	Maryland	lental fental rked c	To Be	Zell Lambert	Jr.			Jacquili	ine Re	entlev	
1	lary	2 should and Men Is marke sumatic	-	19a. Informant's Name/Relationship		19b. Mailing	g Address (Street a		l Route Number, City		o Code)
10	Σ,	and 2 ealth m 27 I		Edward Nelson Bro			ipper Roa		Maryland	21221	C = = 1
0	Baltimore,	it of H If Itel or oth		20a. Method of Disposition 1X Burial 2 Cremation 3		. Place of Dispos cemetery, crem	ition (Name of atory or other place	a)		Location - City or T	own, State
M	Itim	it. Pa intmen intent: injury		4 □ Donation 5 □ Other (Special21. Signature of Funeral Service Lice			f Faith (Ltimore, M	Maryland
\	Ba	permit. Departrimporte any inju		21. Signature of Fulleral Service Lice	7 //	Br	uzdzinski	s of Facility Funeral	Home PA	>1 3	3 21221
11	3 33	ije:		23a. Part1. Enter the disease, or cert	pplications that caused the de	ath. Do not ente	r the mode of dying	ascern Ave g, such as cardiac of	enue Esse respiratory arrest,	ex, Maryla	Approximate
4		Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	- (21400	EM			Interval Between Onset and Death
Z,		/Medical		resulting in death)	Due to (or as a conse	equence of):	CAIOC				OYEARS
d'a	1	Examiner	L.	Sequentially list conditions,	b						
d 1/1	J.	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of as a cons	equence of).					
V	,	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):					
1	3760	ate be nysicia he bur	Icai		d						
bent	. Box 68	The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	23c. If yes, outcome of preg	ital death 3 🗀 l	Ectopic pregnancy Other (specify)			23d. Date of deliver	ery Day Year
AN	P.0	at the de 1 by the a stached	Phys	9 🗆 Unknown	9□ Unknown	71000					
4 12	ecords,	w requires tha been signed I should be det	þ	Part II. Dther significant conditions	contributing to death but not re	esulting in the un	derlying cause give	n in Part I.		use contribute to to	
وي.	eco	e law requ has been je 2 shoul	Completed						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
7			Com						performed?	death?	2 No
I	Vital	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hansitali		Lou	26. Place of Death	Check onl. one)		
2	of	Phys this al dir	2	1 Yes 2 No		ER/Outpatient		4 Nursing Hom	e 5 Residence		WHOSPICE
11		fte	tion	1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work' M 1 7	at ? 'es 2 □ No	8d. Describe how inj	ury occurred	
	=	i i i i i e	Certification;	3 Suicide 6 Could not be determined	00 00- 01	home, farm, streetify)			8f. Location (Street a City or Town, Sta	and Number or Rura ite)	al Route Number,
		Hospita 14 hours Funerel tely fillec	edical C	29a. Certifier 12 Certifying Processing Check only one) 1 Medical Example 1	nysician: To the best of my ki miner: On the basis of examinand manner stated.	nowledge, death nation and/or inve	occurred at the time	e, date and place, ar inion, death occurre	nd due to the cause(d at the time, date a	s) and manner as s nd place, and due to	lated. the cause(s)
		To the within 2 To the comple	Me	29b. Signature and title of centrier	C States		29c. License	unmpet	29d. D	ate signed (Month,	Day, Year)
		. 2,20		I (lun)	and da	-	2	9071	D	3-09-	2004
		Δ.		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, P	rint)		MIMOR		
		Sta	to.	31. Date filed (Month & Gark, Year)	32. Registrar's Sign	SEL N	EUTITA	51 BA	MINNOR	FWO	-1201
		Registr		MAR I 2	2004	14 A	made 1				

			1 - For State Registrar	State of Maryland / I	Department of Health and Certificate of Death	Mental Hygien	
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last)	VIS		2. Date of Death Month D MARCH 7	3. Time of Death
1	Examin		4a. Fecility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Dea		c County of Deeth
			LAUREL REGIONAL	HOSPITAL	LAUREL	<i>F</i>	PRINCE GEORGES
ľ	Funeral Director		5. Social Security Number 6. Sex 1%	M 2□F 7. Age (In yrs. last bit	hthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Yea	9. Birthplace (State or Foreign Country) 9. Albany, GA.
	pu ,		Usuel Residence of Decedent	10.0			
	d within 72 hours after death with the Maryland jeene. r than "natural", or items 23a or 28a-f show the Maulical Examinar must be notified at	ō	10a. State 10b. County PRINCE	10c. City, Tow			10d. Inside City Limits 1 ☐ Yes 2 No
	28a-	rect	10e. Street and Number	o con je	Washing Fon	10g, C	Citizen of What Country?
	th with	Funeral Director	938 EAST	SWAN Creek			USA
	r dea	ner		2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 →No Specify:		Specify: Black
9	2 hou	ted	15. Decedent's Educ	ation 16a	Decedent's Usual Occupation	16b.	Kind of Business/Industry
21215-0036	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)		lonstruction
	e filed w Il Hygier other th		17. Father's Name (First, Middle, Last)		Carpenter	me (First, Middle, Maide	
Maryland	0 = 0 \$	To Be	unknown			gie Wi	
ary	should by and Menta is marked	ř	19a. Informant's Name/Relationship (Typ	e, Print) 19b	. Maifing Address (Street and Number or R	ural Route Number, City	or Town, State, Zip Code)
	1 and 2 Health a iom 27 is		AliciA Lewis	8	Warnunght St. And Disposition (Name of the Care of the	+#3 Nework	L.NJ. 07112
ore			20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3 ☐ Re	moval from State _	ry, ordinatory or other place)		
Baltimore,	C 00 -3		*4 □ Donation 5 □ Other (Specify)	Metr	o Crematory Mar	17,2004 Ba	Itemore, MD
Ba	permit. Departm Importa any inju		21. Signature of Funeral Service License	agreen)	22. Name and Address of Facility Runala H. Gray Sc 108 W. North	n Funeval	Home MD 21201
100			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do	not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition resulting in death)	Concer of	PROSTATE WITH	METASTICE	Onset and Death
	/Medical Examiner		resulting in death)	Doe to (or as a consequence	of):		
		ıer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):		
	cuted nd ransit	Examiner	that initiated events C.				
8760,	be exectan a		resulting in death) Last	Due to (or as a consequence	of):		
687	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	edicai	. d.				
Box (n certii anding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy	ACI		23d. Date of delivery
	e deat he atte	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.O.	hat the	Phy	9 ☐ Unknown Part II. Other significant conditions cont		the underlying cause given in Part I	23a Did tahaasa	use contribute to the cause of death?
of Vital Records,	se be	d by	Tarin one organization of the	nooting to death but not resulting in	The didenying cause given in Fatti.	1 Tes 2	C 1
CO	aw requir s been si 2 should	piete				24a. Was an	24b. Were autopsy findings available
Ä		Completed				autopsy performed? 1 ☐ Yes 2 ☐ N	prior to completion of cause of death? 1 □ Yes ② No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	spital		ath (Check only one)	
ot	Phys r this ral dir	7. To	1 ☐ Yes ②X No 27. Manner of Death	Nnpatient 2 ER/Ou		lome 5 Residence	
ion	Attending Physician: If death. ector: After this certified by the funeral director, it	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Time of njury 28c. Injury at Work? M 1 □ Yes 2 □ No	Ess. Boss. Bo now and	ary occurred
Division	f or Atte after de Directo I in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number,
	Hospitel		29a. Certifier Certifying Physi	cian: To the best of my knowledge	s, death occurred at the time, date and place	and due to the cause/e	Nond manage of stand
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examine one)	er: On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occu	rred at the time, date an	d place, and due to the cause(s)
-	To the within 2 To the complet	Σ	29b. Signature and title of certifier	H C M	29c. License number	29d. Da	ate signed (Month, Day, Year)
	2		30. Name and address of person who con	inpleted cause of death (Itam 22a)	Type Print)	MH	KCH 1- 2007
_	3		SYIDD SADIQ	14333 LAURE	A BOWLE ROAD ?	7208, LA	RCH 7 2004 RCH 1 2004 WILL MD 20108
1	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 2 2004	32, Registrar's Signature	Soul		

			1 - For Amend Item 24a pe	er State of Maryland/(Department of Public Certificate	of Health and of Death		iene 2004	07972
п	Physic	an	Decedent's Name (First, Middle, Last	;)	Mn		2. Date of Death Month	Day Yeer	3. Time of Death
¥	/Medi		Lacey		Mon			26 04	1:49 P M
	Exami	ner	4a. Fecility Name (If not institution, give			wn, or Location of Dea	4	4c. County of Deat	incore
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs., last bi	inthday) If Under 1	rear If Under 24 Hr			hplace (State or Foreign
	Director	1	133-48-5895 N	Z41 20 F 74		Days Hours Mir	n. (Month, Day,	129 NO	Il Caroline
	p >		Usual Residence of Decedent 10a. State 10b. County	100 00 7				100.	TICE CITIES
	rs after death with the Maryland ", or tems 23a or 28a-f show pariting must be confilled at	5	M T	10c. City, Tov	m or Location	_			10d. Inside City Limits 1 Yes 2 No
	the N	Director	10e. Street and Number	Bal	10f. Zip Co	2	10	g. Citizen of What Co	
	3a or	io.	431 Notro. Do	10 1 aug. 12t.	112 21	210		ICA	unity :
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Deceden	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ame	rican Indian,
9	after or tte		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2002 No If Yes, Give	_		rto Rican, etc.)	Black, White	e, etc.
5-0036	72 hours after natural', or ite	d by	3 Widowed 4 Divorced	Year or Dates:	1 🗆 Yes 2 🧲	No Specify:		Specify: 3	1ac/C
5-(72	Completed	15. Decedent's Edi (Specify only highest grad	ucation 16a le completed)	. Decedent's Usual C (Give kind of work of	tone during most of w	orking	6b. Kind of Business/	industry
2121	within iene. than "	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use r	a interior	, -	TAIRLE	trial -
	illed within I Hygiene. other than	Be Co	17. Father's Name (First, Middle, Last)		UNSI	18. Mother's Na	ame (First, Middle, M	aiden Sumame)	
lan Lan	should be nd Mental marked c	ToB	Quen Hockest	Smill		Arro	alia. 1	MODIFO	6
Maryland	ges 1 and 2 should be filed wit of Health and Mental Hygiene If item 27 Is marked other that or other traumatic event, tha		19a. Informant's Name/Relationship (T)	/pe, Print) 19t	o. Mailing Address (Si	treet and Number or F	Rural Route Number,	City or Town, State, Z	ip Code)
	is 1 and 2 of Health item 27 I		EUNICE MON	roe (WiFe) 4.	31 Notr	e Danel	ave Ao	t.113 Ba	FOMDALS 15
ore	of He of He or oth		20a. Method of Disposition Burial 2 □Cremation 3 □F		of Disposition (Name or ry, crematory or other	of r place)	Date 2	Oc. Location - City or	Town, State
Ë	Pag iment tant: jury c		*4 □Donation 5 □ Other (Specify)		ern Ceme	tery 3/4	404 1	30140.1	\mathcal{D}
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licens	99	P2/Name and A	ddress of Facility	ens Fre	neral S	ervices)
	40200		Eun W.	sun	140	YORK	, Id. Bal	D.MD	21212
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.	not enter the mode of	f dying, such as cardia	ac or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	ric Car	& dio myo	pathy.		
***	Examiner			Λ	_	J	01 0		
	e g	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence		oronary	Steat		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	,					
o,	be execu ician and burial-tra	Еха	resulting in death) Last	Due to (or as a consequence	of):				
8760,	cate be executed physician and the burial-transit	dical	(d					
9	ing ph	Med	IF FEMALE:						
Вох	that the death certifined by the attending I	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death	3 □Ectopic pregn	ancy		23d. Date of deliv	,
_	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specif	y)		Month	Day Year
P.O.	res that the igned by t be detach	Ph	Part II. Other significant conditions co.	ntributing to death but not resulting in	n the underhand cause	a gwan in Bart I	23e Did toba	cco use contribute to	the squae of death?
Records,	89 P 90	d by	acute x	ral Jailine	in the underlying cause	e giveirii Fait I.			bably 4 Unknown
Ö	w requir been si should l	ete	C" 1000 0 0 1	Out days	- 4.5				
Rec	rsician: The law s certificate has t lirector, page 2 s	Completed	Conordy	arrey au se	gre		24a. Was an autopsy performe	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
a		e Co	25. Was case referred to medical				performe 1 ☐ Yes 2 2		2□ No
of Vital	Physician: this certificatal director, p	To Be	examiner?	lospital: 1 Inpatient 2 ER/Ou	stpatient 3 DOA	OH	ath (Check only one)		
0	g Phys er this eral di	T. T	27. Manner of Death	28a. Date of Injury 28b.		Injury at Work?	28d. Describe how	ce 6 Other (Speci	fy)
ion	nding F ath. r: After e funera	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		Work? 1 ☐ Yes 2 ☐ No			
Division	er der	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa	rm, street, factory, off	lice	28f. Location (Stre	et and Number or Rur	al Route Number,
Ö	tal or	Cert	Tomode	building, etc. (Specify)			City or Town,	State)	
	hour uner uner	cai	29a. Certifier 1 Certifying Physical Examination	sicien: To the best of my knowledge ner: On the basis of examination an	, death occurred at th	ne time, date and place	e, and due to the cau	se(s) and manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	Medical		and manner stated.			urred at the time, date	e and place, and due t	o the cause(s)
	To To	~	29b. Signature and title of certifier	• (0		cense number		I. Date signed (Month,	
			(gym	((Resident)		(Es 00	0	02/26	104
			30. Name and address of person who co			1 0 ~ 11.		- 1 a a	70
	Sta	10	R. Mishra, G 31. Date filed (Month, Day, Year)	od Sanartan 32. Registrar's Signature	Maspila	i , rough	nn -0 1	up 21	257
	Registr		MAR 1 2 2004	And A	and a				

State of Maryland / Department of Health and Mental Hygiene 1 07973 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Yeer 7-59PM MARCH ELLEN PATRICIA McLEE 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEALTH LARE AGNES BALTIMORE
If Under 1 Year If Under 24 Hrs. 8.0 N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🕅 F 216-68-5762 Yrs. Director 46 Aug. 24, 1957 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show other traumatic event, the Medical Evaryings must be politied at 1 √Yes 2 No M.D. N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1104 St. Agnes Lane 21207 U.S.A. 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 28 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Alcohol & Drug Elementary/Secondary (0-12) College (1-4or 5+) Abuse Administration 1vear Fisca Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H is marked of Cleveland Bunn, Sr. Pages 1 and 2 should Betty Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. 1104 St. Agnes Lane Balto. M.D. 21207 Ventura McLee- Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cem. 3/12/2004 Pikesville, M.D. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Nutter Funeral Home Inc. 21. Sigrature of Funeral Service Licenses 2501 Gwynnsfalls Pkwy., Balto, M.D. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN STEM **Physician** HERNIATION IDAY /Medical Due to (or as a consequence of): **Examiner** DAY YDROCEPHLUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown vate nas been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) ANMEET KAUR MD MARCH, 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OI MANMEET KAUR ST AUNES HEALTH CARE 900 S. CATON AVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 1 2 2004 Great 1

State of Maryland / Department of Health and Mental Hygieney 17976 State
RegistrarAMFND ITFM #10e&19b PFR FH G829 3/1964 tifficate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MADDOX Yee DOLORES CECELIA 2004 5:40 PM MARCH /Medical 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Deeth HOSP ITAL BALTIMORE GOOD SAMARITAN 8. Date of Birth (Month, Day Year) May 11, 1920 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) Funeral Days Min. 1 ☐ M 2 🔀 F 83 213 30 8115 Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examinar must be notified at Maryland Baltimore Middle River 1 ☐ Yes 2 X No Directo 10e3 Street and Number 10f. Zip Code 10g. Citizen of What Country? 11315 Cherwin Avenue 21220 USA Items 23a death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 0 White 1 ☐ Yes 2 ☒ No 3 Widowed 4 Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be of Health and Mental Ham 27 Is marked or r other traumatic eve Mental Charles Alexander Helen Reese 19a. Informant's Name/Relationship (Type, Print) 195 Marting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11315 Cherwin Avenue Baltimore, Maryland 21220 James V. Maddox Sr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Holly Hill Mem. Gardens 3/12/2004 Baltimore, Maryland A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK /Medical Due to (or as a consequence of) Examiner INTRABDOMINAL ABCESS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). transit. The law requires that the death certificate be executed Exami METHICILLIN PESISTANT STAPHYLOCOCCUS and burial-t Due to (or as a consequence of): AUREUS Box 68760. physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No o. 9 Unknown 9 Unknown م Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Division of Vital 1 Yes 1 ☐ Yes 2 ☑ No 2 12 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification; To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. controletely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kurunlla MD PES OOD MARCH 09 2004-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUJJIH KUKUVILLA, 5601 LOCH RAVEN BOULEVARD Cool ! BALTIMO MARYLAND 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 07975 1- Standen Item#17, per FH, G829, 3/19/04, CC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>004</u> **Physician** Month March 9 McCleery Dora 1915 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar 31,1917 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M XXF Months 579-03-8764 86 Washington DC Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle r 28e-f show 1 ☐ Yes 3/TXNo MD Anne Arundel Edgewater Direct 10e Street and Number 10f Zip Code 10g. Citizen of What Country? ö the Madical Examiner must be 1411 Nancy Street 21037 USA 23a Funerai or itema 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Malcolm Holloway and Mental h Pages 1 and 2 should be James Malcolm Phyllis Olive Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 is Richard Hunt (Nephew) 3807 Lake Blvd., Annandale, VA 22003 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if Itel
any injury or ott 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 3/12/2004 Baltimore, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Hardesty Funeral Home, P.A Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Multisagen Organ Due to (or as a consequence of): **Physician** /Medical Examiner epsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit i territis Due to (or as a consequence of) 11 Bowel Obstruction Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery sed by the atten 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ E g 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has autopsy performed certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To completely filled in by the funeral 27. Mann eath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital 1 artifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of confi 29c. License number 29d. Date signed (Month, Day, Year) Dec 58297 10 30. Name and address of person ∳ho completed cause of death (Item 23a) (Type, Print) Anne Drundel Metral Canta MI

Registrar DHMH 17 Rev 1/200

State

31. Date filed

Registrar's Signature

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Funeral Director			Sex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 06 28	Year) 84 Ar	B. Birthplace (State or Foreign Country) clington, VA.
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28e-f ehow any injury or other traumatic event. If a Medical Erath partment be mailiad at ODCe.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	,	42-	Was Decede f Yes, specif 1 Yes 2	_	spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)		Black, Whi	erican Indian, ite, etc. Vhite
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Baltimore,	Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition 1. Burial 2 Cremation 3 . 4 Donation 5 Other (Specify		Cé	lace of Dispo emetery, crer red He	natory or oth	er place	ery 3	Da 3/15/			ation - City or	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	388										eral Home 1 20715
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as	ne. 25/14	La catev Lence of): Otherwise of):	er the mode	of dying A/	Les	eardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
,8260,	death certificate be executed e attending physician and ind for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):								
P.O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, out <i>co</i> me 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre					2:	3d. Date of de Month	olivery Day Year
	9 P 9	by	Part II. Other significant conditions or	ontributing to death b	out not resu	ilting in the u	nderlying cau	ıse give	n in Part I.			obacco us 'es 2 🗆		o the cause of death?
Vital Records,	The law ate has b page 2 s	Completed				· · · · · · · · · · · · · · · · · · ·					24a. Was autop perfor 1 Yes	sy	24b. Were a prior to death?	utopsy findings available completion of cause of
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				04		of Death (Check only o	ne)		
of	S S D	tion: To	1 Yes 2 No 27. Manner of Death 1 Autural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry	ER/Outpatier 28b. Time o Injury		c. Injury Work	4 11411	28	e 5 🗀 Resid			ecify)
Division	i te	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et			eet, factory,	office		28	Bf. Location (S City or Tow		Number or R	ural Route Number,
	the Hospital hin 24 hours a the Funeral I npletely filled	edical	29a. Certifier 1 certifying Phyone) 2 Medical Exem	valcian: To the best iner: On the basis of apro manner st	of examinat	wledge, deatl ion and/or in	occurred at vestigation, i	the tim	e, date and inion, deatl	place, an	d due to the o	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)
-	To the within To the comple	×	29b. Signature and title of certifier	A.			29c.	License	number	94		29d. Date		th, Day, Year)
10	7 '			swiels	Au	he ?	7 int 1/4 W	del	A	ecli.	and (cert	en	
8	Sta Regist		31. Date filed (Month, Day, Year)	32. Registr	rar's Signat	ture								

04-01688 Mary RJD

	7 Oliveri	io	Please	Type or Prin	nt in Blaci	k Ind	elible Ink	. Ensure Al	II Copies	Are	Legible.	
RJD			For State Registrar		aryland / [Depa Cert	rtment of F	lealth and M Death		Reg. No	·	07978
	Physicia /Medica		Decedent's Name (First, Middle, L.	Mar					2. Date of De Month March	7, Da	2004	3. Time of Death 0051A M
	Examine	er	4a. Facility Name (If not institution, gi Bayview Medical				4b. City, Town, of Baltimo	r Location of Death		40	c. County of Dee N/A	th
	Funeral Director		Social Security Number 6.		e (In yrs. last birt	thday)_ Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, De Feb	th ay, Year, 12,1		thplace (State or Foreign ountry) st Virginia
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loc	ation					10d. Inside City Limits
	Be-f sh	Director		ltimore				D u nda1	.k			1 ☐ Yes 2∕Q3No
	3a or 2	Dir	10e. Street and Number 6585 St. Helen	a Avenue			10f. Zip Code	21222		-	itizen of What Co nited S1	•
036	S SIL	by Funeral	11. Marital Status 1 Never Married 2 Married MWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			as Decedent of F Yes, specify Cubi	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whit Specify:	
5-0	natur	eted	15. Decedent's E (Specify only highest g	ducation ade completed)	16a.	(Give k	int's Usual Occup and of work done O NOT use retire	during most of work	ing	16b. K	(ind of Business	/Industry
2121	withir piene.	Completed	Elementary/Secondary (0-12) 8 Years	College (1-4or 5	5+)	me. Do	Homemak	•			Own Home	9
bu	2 should be filed w n and Mental Hygien is marked other ti raumatic event, th	Be	17. Father's Name (First, Middle, Las	t)	· · · · · ·			18. Mother's Name			,	
ıryla	should od Men marke matic	၉	Luigi Mancuso 19a. Informant's Name/Relationship	- (Type, Print)	19b.	. Mailing	Address (Street	and Number or Rura	ella Ir			Zin Codel
⊠	and 2 salth ar n 27 ls		Mr. Dennis L. Ol				S. Potom				Maryland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked sny injury or other traumatic events.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3			y, crema	tion (Name of atory or other place slaus Ce	ce)	2004		ocation - City or	Town, State Maryland
altin	mit. P. partme sortani y injury		* 4 □ Donation 5 □ Other (Spec	LI U	, se	-		ss of Facility 1 H				
Ö	ed a man		Jul 111	In VIII	/	79	922 Wise	Ave. Du	ndalk,	Mar		21222
	Pnysician /Medical Examiner		23a. Pert Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one caus of each line	a consequence of	otic	the mode of dyin	g, such as cardiac o	or respiratory a) Ld (وديو	Approximate Interval Between Onset and Death
130	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence o							
3876	physic physic s the b	dica		d.								
Division of Vital Records, P.O. Box 687	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		ictopic pregnancy Other (specify) _				23d. Date of del Month	ivery Day Year
ords, P	w requires that the debeen signed by the a should be detached f	by P	Part II. Other significant conditions	contributing to death b	ut not resulting in	the und	lerlying cause giv	en in Part I.	T	obacco (Yes 2		the cause of death?
al Reco		Completed							24a. Was auto perfo 1 \(\text{Yes} \)		death?	topsy findings available completion of cause of 2 No
Vit.	Physician: this certifical	o Be	25. Was case referred to medical examiner? 11	Hospital: 1 ☐ Inpatie	ent 2 🔯 ER/Out	tnatient	3□ DOA Oth	26. Place of Death	-		6 ☐Other (Spec	nifel
ion of	Jing After fune	ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Da)			28c. Injur Wor		28d. Describe	_		any)
Divis	itel or Attend rs after death el Diractor:	OL	3 Suicide 6 Could not a determined		ury - At home, far c. <i>(Specify)</i>	rm, stree	t, factory, office		28f. Location (: City or To	Street ar wn, State	nd Number or Ru e)	ral Route Number,
	To the Hospitel or Attent within 24 hours after dealt To the Funerel Director: completely filled in by the	Medical	(Check only one) 21 XMedicel Exe	hysician: To the best of miner: On the basis of and manner sta	examination and	, death o	stigation, in my o	pinion, death occurr	ed at the time,	date and	d place, and due	to the cause(s)
•	T With		29b. Signature and title of certifier	enel			O.C.N	i.E.		Mar	te signed (Mont) Ch 7, 20	004
	5		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Pr	int) 111 Pe	enn Street	, Balt	imor	e, Mary	land 21201
	State Registra		31. Date filed (Month, Day, Year)	2 2004 32. Registra	ars Signature	A C	Julis	-				

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** Maccio Anna March 2004 10 8:45 PM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Conley Baltimore sattmore If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 10/8/1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☐ M 2 🕱 F 213-12-4725 84 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location Show 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryle Department of Health end Mentel Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2000No Funeral Director MD Baltimor Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7024 Conley Street 21224 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed by 3₺ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael Misczuk Mary Azzcki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Micheal Oliaccio/Son 7024 Conley Street, Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Saint Stanilaus 4 ☐ Donation 5 ☐ Other (Specify) 3/13/04 Baltimore, Maryland 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Funeral Service Licensee 6224 Eastern Avenue Baltimore, Maryland 21224 plications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Cancer disease or condition resulting in death) Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician e for use es the buriel-Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? s certificete has I lirector, page 2 s 1L Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funerel director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Natural Accident 5 Pending investigation To the Hospital or Attendin within 24 hours efter deeth.

To the Funeral Director: Aft completely filled in by the fur 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , nio March 11th, 2004 Kachelle D56705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAJADHAR, 5505 HOPKINS BATVIEW CIRCLE, BALTIMORE MD 21224 RACHELLE 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

32. Registrar's Signature

MAR 1 2 2004

State of Maryland / Department of Health and Mental Hygiene 2001 07980

		Certificate of Death	Reg. No.	J4 01306
Time to	Decedent's Name (First, Middle, Last)		2. Date of Deeth Month Dey You	3. Time of Death
Physician /Medical	Adeline Angela Pribyl		3 7 20	ear 11:55 PM
Examiner	4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or L	ocation of Death 4c. County of	Deeth
	Lorien Nursing Home - Bel Air	Bel Ai	r HARI	FORD
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. lest	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9	. Birthplace (State or Foreign
Director	216-12-2767 1□M 2♥F 80	Yrs. Months Days Hours Min.	July 5, 1923	Birthplace (State or Foreign Country) Maryland
70	Usuel Residence of Decedent			
arylan show dat		own or Location		10d. Inside City Limits
Mar Tor	Maryland Baltimore	Baltimore		1 ☐ Yes 2 💢 No
ith the Mar or 28a-f sl	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	at Country?
S S	4220 Winterode Way	212	36 U.S	S.A.
d 21215-0020 filed within 72 hours after death with the Maryland Hygiene. ther than 'natural', or items 23e or 28e-f show but, the Medical Examiner must be northed at a Completed by Funeral Director	11 Marital Status 12 Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- 14. Race -	American Indian,
Fe France	Armed Forces? 1 Never Married 2 Married 1 Yes 2 XNo		Rican, etc.) Black, 1	White, etc.
urs a urs a by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:	Specify:	White
21215-0020 d within 72 hours att gianna. rr than "natural", or the Mexical Exam completed by F	15. Decedent's Education 10	6a. Decedent's Usual Occupation	16b. Kind of Busin	ness/Industry
1 21215-0 ad within 72 ho ygiana. er than "natura ft, the Mexical E	(Specify only highest grade completed)	 Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) 	ring	
than an an an an an an an an an an an an a	Elementary/Secondary (0-12) College (1-4or 5+)	Meat Cutter	Food Se	rvice
d Hygin Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)	
Maryland d 2 should be file the and Mantal Hy 7 is marked oth traumatic event To Be (George J. Koerner	Marie 1	3. Longenmiller	
aryla should and Man merke umetic		9b. Mailing Address (Street and Number or Ru.		ate Zin Code)
Mar d2shc th and 7 is me traum		14 Vista View Court, 1		21087
		of Disposition (Name of	Date 20c. Location - Cit	
	1 X Burial 2 Cremation 3 Removal from State	ntery, crematory or other place)		•
Baltimore, semit. Pagas 1 ar appartment of Haa mportant: if item; iny injury or othe			3/10/04 Baltimore	
Baltimo pemit. Paga: Dapartmant of Important: If I any Injury or phice.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sc.		
m 405 # 9	Mall	9705 Belair Rd.,	Baltimore, MD 27	1236
Physician /Medical Examiner		STRUCTIVE LUNG DIS, a consequence of):	EASE, ENDSTAGE	Onset and Death
ox 68760) cartificate be executed ding physician and sa as the burial-transit	if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury c	a consequence of): a consequence of):		
	d			-
. 8 as 9	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23b. Did tobacco use contril	bute to the cause of death?
Bry the etache			1 Yes 2 No 3[☐ Probably 4 ☐ Unknown
	CONGESTIVE HEART FAI	LURE		
rd; n sig uld b	PLEURAL EFFUSIONS			4b. Were autopsy findings available prior to
Tha law raquire Tha law raquire pata has bean si paga 2 should Completed	PLEURAL EFFUSIONS		performed?	completion of cause of deeth?
II Re(Tha lav tata has paga 2			1 - ON-	
C Trate	05. West and the second		1 □ Yes 2 No	1 ☐ Yes 2 ☐ No
r Vital I ysician: The is certificata diractor, par To Be Co	25. Wes case referred to medical examiner? Hospital:	0.0	th (Check only one)	
hys this aldii	1 Inpatient 2 EH/	Outpetient 3 DOA 424 Nursing Ho	ome 5 Residence 6 Other	Specify)
SION O lending Ph leath. lor: Aftar thi tha funaral	1 Natural 5 Pending (Month, Day Year)	o. Time of 28c. Injury et Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
DIVISION Of VITAI RECORDS, balor Attending Physician: The law requires the state death. In Director: After this certificate has been signe in the funeral director, page 2 should be Certification: To Be Completed by	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (Street and Number of City or Town, Stete)	or Rural Route Number,
Division To the Hospital or Attention within 24 hours after daat To the Funeral Director: complataly filled in by the Medical Certifica	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of exemination end manner steted.	ge, death occurred at the time, date end place, end/or investigation, in my opinion, death occur	and due to the cause(s) and manne red at the time, date and place, and	er as steted. I due to the cause(s)
To the within roomp	29b. Signature end title of certifier	29c. License number	29d. Date signed (M	Month, Day, Yeer)
	Justillagou Mi	1 45344	07/-	0/20011
6	30. Neme end eddress of person who completed cause of death (Item 23e	0 1 - 1	05/00	8/2004
v)	SURESH) HAN JAN I MD 622	S. UNION AVE ITAVRI	e Ne conse la	1 0070
	SURESH) HAN JAN JAN 6225 31. Dete filed (Month, Day, Year) 32 Registrar's Signature	S. UDION AVE ITAVKI	OR GRACE MI	21010
State	MAD 1 2 200/	marie		

State of Maryland / Department of Health and Mental Hygiene 2004 07981 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6.10 PM Jackie D. Powell MARCH 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | 7...0...01 | 10 N/A 400D SAMARITAN HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 □ F 220-34-7398 65 July 21, 1938 West Virginia Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 ☐ Yes 2 🗙 No Maryland Harford Bel Air Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 1003 Thomas Run Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Itams 11. Marital Status the Madical Executors 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced White natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than College (1-4or 5+) Hygiene. 12th Grade Steel Worker Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H fillem 27 is marked off rother traumatic even Be Evelyn Powell Lillu Herman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4219 Darleigh Road, Baltimore, MD Mr. Brian D. Powell (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 to 1

Burial 2 □ Cremation 3 □ Removal from State permit. Pages Department of Important: If It any injury or or 3/12/2004 Gardens of Faith Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21.(Signature of Funeral Service Licensee 9705 Bekuir Rd., Baltimore, MD 21236 Part I. Enter the disease, or complications that caused harmath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition SEPSIS **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner INFECTION Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by PARAPLEGIA 1 Yes 2 No 3 Probably 4 ⊠Unknown 24b. Were autopsy findings available prior to completion of cause of death? KENAL 24a. Was an autopsy page performed? or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🗷 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KNOWON RES DOO MARCH 8 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOLH RAVEN BLVD BALTINORE MID 21286 ROHINI NORONHA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 2 2004 ▶ Registrar

Power

		4	For State Registrar	State of Maryland / D	epartment of He	ealth and Me Death	ental Hygien Reg. N		07982
	Physici	_	1. Decedent's Name (First, Middle, Last) FREEMAN		PITTS		Month Da	y 2004	3. Time of Death 6.50 PM
	/Medic Examin	er	4a. Fecility Name (If not institution, give HARISCR HOST 5. Social Security Number 6. Se:	ITAL CENTE		If Under 24 Hrs. 8	E Date of Birth	c. County of Death NA 9. Birtho	place (State or Foreign
e E	Funeral Director		0. 000.2. 000,	3 oO =	rs. Months Days	Hours Min.	(Month, Day, Year 10-7-37	r) Cour N.	
	aryland show	_	10a. State 10b. County	10c. City, Town				1	0d. Inside City Limits 1 Yes 2 □ No
	with the M a or 28a-f be notifie	Director	Md. NA 10e. Street and Number 2424 E. Federal S	Balts	101. Zip Code 21213		10g. C	itizen of What Cour	ntry?
336	be filed within 72 hours after death with the Maryland tal Hygiene. Id Hygiene. Id other than "natural", or items 23e or 28e-f show other than "natural", or items 23e or 28e-f show event, the Medical Examination trival te	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
Maryland 21215-0036	d within 72 hou piene. r than "nature the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed)	Decedent's Usual Occupa Give kind of work done di life. DO NOT use retired) Superindeno	uring most of working	7	Kind of Business/Inh.	
and.	B a b ≥	To Be C	17. Father's Name (First, Middle, Last) Eddie	Long		18. Mother's Name (n Sumame)	tts
	2 sh and and ls m	ř	19a. Informant's Name/Relationship (7)		Mailing Address (Street a		·		
altimore,	Page ment o ant: If ury or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State 20b. Place of cemetery Garris	Disposition (Name of r, crematory or other place son Forest V	Pet 3-15-	te 20c. I	Location - City or To ings Mill	
Balt	permit. Departm Importa any inju		21. Sunature of Funeral Service Licens	Walter -	22. Name and Address March F.H.	Fast	1101 E. N	ore, Md. orth Ave.	21202
	Pnysician /Medical Examiner		23a. Part. Enter the disease, or compositock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Liver M Due to (or as a consequence of Cancel	Itaskise.	8	respiratory arrest,		Approximate Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or as a consequence of d.					
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ery Day Year
ds, P.	uires that signed by	ρ	Part II. Dther significant conditions of	1 - 1	- '	on in Part I.		use contribute to to 2 No 3 Prot	
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Division of Vital Records,	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	To Be	27. Manner of Death 1 Matural 5 Pending	28a. Date of Injury 28b. T	njury Work	4 Nursing Hom	(Check only one) e 5 Residence 3d. Describe how inj		(y)
Divisio	el or Attending s after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)			8f. Location (Street a City or Town, Sta		al Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled:	edical	(Check only 2 Medical Examone)	ysician: To the best of my knowledge liner: On the basis of examination and and manner stated.		pinion, death occurre	d at the time, date a		o the cause(s)
	t with	Σ	29b. Signature and title of certifier	a (intern)	RE.			3 - 8 -	
	sı	ate	30. Name and address of person who do the state of the st	completed cause of death (Item 23a) (7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Type, Print)	SPITAL	CENTE	R, BA	LTIMORE
D	Regist	rar	MAR 1 2 2004	Germa A	Sparket	- 9			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 07983 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Y. March 10, 2004 Year **Physician** Margye Mahard Precht 11:10 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9 9 yrs. | Months | Days | Hours | Min. | Dec 8 , 19 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□ M 2□F Texas 465-54-6473 1904 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show 1 ☐ Yes 2 ☑ No Howard Columbia Direct 10f Zin Code 10g. Citizen of What Country? 10e, Street and Number 21044 6336 Cedar Lane United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ₩idowed 4 Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Education College (1-4or 5+) Elementary/Secondary (0-12) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Andrew Parvin Mahard Maggie Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any njury or other traum once. Mrs. Margye Hixson/Daughter 6028 Flywheel Court, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Mar 12 1 □ Burial 2 ☑ Cremation 3 □ Removal from State Chesapeake Crematory 2004 Beltsville, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives faill MO0986 8717 Green Pastures Drive Baltimore, MD Approximate Interval Petween Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Box 68760 Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should he detached for use or the home. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ deser 1 ☐ Yes 2 7 10 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Vatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signatu son who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar 2 2004

				1 - For State Registrar	State of	Maryland / [Depai <i>Cert</i>	tment of F	lealth and M <i>Death</i>		ene 0	04	07984
		Physici /Medic		Decedent's Name (First, Middle,	Last) David	Willia	ım E	arker		2. Date of Death Month March(3)	Day /	2004	3. Time of Death
		Examir		4a. Facility Name (If not institution, Johns Hapkins			Her	4b. City, Town, o	r Location of Death			y of Deeth	
		Funeral Director		213-68-9832	6. Sex 7. 1 ★ M 2 □ F	Age (In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) March 7,		Count	ace (State or Foreign try) /land
		Maryland -f ehow	tor	Usuel Residence of Decedent 10a. State 10b. County	ltimore	10c. City, Tow	m or Loca	ation	Dundalk			10	Od. Inside City Limits 1 ☐ Yes 2 ☑ No
		with the M is or 28a-f	Director	109. Street and Number		902		10f. Zip Code	212-22	10		What Count	•
David	96	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28a-f ehow int, the Mcdical Examiner must be multied at	y Funerai	11. Marital Status 1 Never Married 2 Marrie	12. Was Decede Armed Force 1 Yes 2	ont Ever in U.S. es? No		as Decedent of H Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ce - America ick, White, e	an Indian,
<i>[-1]</i>	21215-0036	n 72 hours "natural", edical Exe	Completed by	3 ☐ Widowed ♣☐ Divorced 15. Decedent' (Specify only highest	Year or Date		. Decede	nt's Usual Occur	ation during most of worki	ing 16		Wh:	
Parker,	d 212	be filed within that Hygiene. Be other then event, the Merenthen the manner t	e Comp	Elementary/Secondary (0-12) 10 Years 17. Father's Name (First, Middle, L	College (1-4	or 5+)		hinist	18. Mother's Name	(First, Middle, Ma		factui	ing
5	Maryland	0 000	To Be	Amos C. Parker		ster 19h	Mailing	Address (Street	and Number or Rura	Trosy M.			Code
	e, Ma	s 1 and 2 should f Health and Mer Item 27 le marke other traumatic		Mrs. Deana Par		Law 6	327		Road Ch	nase, Mar	yland	2122	20
	Baltimore,	t. Page rtment o rtent: If njury or		1 Burial 2X Cremation 1 Denation 5 Other (So	ecity)	te cemeter	ry, crema .op S	ervice (Corp. 3/10	0/2004	Towso	- City or Tov	ryland
()	8760, B	cate be executed XX EX Department of the burial-transit once and the burial-transit once any it.	dicai Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a season of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. End a Due to (or b. Acute Due to loc	seche death. Don the. Has a consequence as a consequence as a consequence	of):	22 Wise the mode of dyin	Ave. Dun g, such as cardiac o	dalk, Ma	ryland	212	Approximate Interval Between Onset and Death VearS
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	rds, P.	quires that the density of a signed by the signed by the side detached	d by Ph	Part II. Other significant condition	ns contributing to deat	h but not resulting in	n the und	erlying cause giv	en in Part I.		cco use con		cause of death?
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	Division of Vital Records, P.O.	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification;	27. Manner of Death 1	ation	njury 28b. T Day Year) li Injury - At home, fa etc. (Specify)	Time of njury		/ at 2 <br Yes 2 □ No	28d. Describe how 28f. Location (Stre City or Town,	injury occur	red	
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	_	y		30. Name and address of person was T. Berkeley 494	to completed cause of	f death (Item 23a) (AVENUE,	(Type, Pr	7µwou	, MD ZI	227			
		Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar Signature	0						

			For State Registrar	State of Ma	arylan	d / Depa	artment of H	lealth and <mark>I</mark> Death		giene2 () () 4	07985
			Decedent's Name (First, Middle, Last)						2. Date of De			3. Time of Death
	Physici		Norma Leigh Reed	ì					March	11,2004	Year	10:40 p ^M
5	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Death		4c. County	of Death	0.10
	LXuiiiii	٠.	1 Brett Court, Apa	rtment 21	4		Essex			Balti	more	
	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. i	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	h		lace (State or Foreign try)
В	Director		218–24–7802) M 2(2XF	75	Yrs.	Months Days	Hours Will.	March	14,1928	West	"
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c Cib	y, Town or Lo	postion				11	0d, tnside City Limits
	aryla shov	<u>~</u>					Callon				, ''	1 ☐ Yes 2 ☒ No
	№ М 28а-1	Director	Maryland Baltimore	•	Ess	ex	10f. Zip Code			10g. Citizen of W	hat Caus	
	a or		1 Brett Court, Apa	rtment 21	Δ		21221			U.S.A.	nat Coun	цуг
	eath ma 23	Funeral	11. Marital Status	12. Was Decedent I		S. 13	Was Decedent of H	lispanic Origin? (S	pecify Yes or No		- Americ	an Indian.
	fter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💆 N			If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)		c, White,	
ğ	hours after death with the Maryland lural', or Itema 23a or 28a-f show al Examinat must be notified at	þ	3 ☐ Widowed 4₩Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 XX No	Specify:		Specify:	Wh	ite
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<u>a</u>	12 sh h and 7 ls n traun		19a. Informant's Name/Relationship (Ty Deborah Reynolds (1	ng Address <i>(Street</i> Riverthorn					
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ဝွ	ages nt of t: If It		1 ☐ Burial 2 💢 🚾 remation 3 ☐ P	lemoval from State			natory or other place crematory		6/2004			
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愈			23a. Part1, Enter the disease, or compl	ications that caused	the death						aryro	Approximate
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ص	that hed by deta	y P	Part II. Dther significant conditions con	ntnbuting to death b	ut not resi	utting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contri	bute to th	e cause of death?
Records,	quires tha n signed ald be del		Coronary A	rtery	DIS	seas	e		101	res 2 PNo	3 🗌 Proba	ably 4 Unknown
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<u>ত</u>	death. ctor: Al	atic	2 Accident investigation				M 1 🗆	Yes 2 □ No				
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	r ≠ - ō		> Seo Sh	W.D	,		DE	3888	2	03/12	110	004
			30. Name and address of person who co	ompleted cause of d	eath (Item	23a) (Type.	Print)					
	\sim		Khalid AL-TO	aliba Mil	> ,	9105	Franklin	Squa	re Dr.	Balti	mure	am s
	Sta		31. Date filed (Aphin) Day, Year) 2004		ar's Signa		0					
	Registi	ar	SAME AS A 10 TO CO.	A CONTRACTOR	Jan Start	A SA						

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Charles F. Rheubottom, Jr. March 11, 3:00am м 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Continuum Care Sykesville Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 21, 194:0 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min 1 ☑ M 2 ☐ F 212-38-1365 63 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location , or Items 23e or 28e-f show aniner must be notified at Carroll Sykesville 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 Oklahoma Avenue 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဤ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: if Item 27 Is marked other this any injury or other traumatic avent, Ins. once. Musician Music 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles F. Rheubottom, Sr. Evelyn Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Mary Rheubottom (Spouse) 407 Oklahoma Avenue, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Springfield Cemetery 3/15/2004 Sykesville, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses HATCHTO FUNERAL HOME & CHAIEL PA (Box 195) Sykesville, ND 21764 (410)-795-1400 23a. Part1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Rener Disease Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hellins The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown certificate has been signed by irector, page 2 should be detac Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hore min 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Y*e*s 21 No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) A30119 3-11-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Sytemille 21784 Kernille 1014612 AOITI AH 2 6212 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 2 2004 Dayers april 1 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			r.	State of Maryland /	Department of Health and	Mental Hygiene	
			1 - For State Registrar		Certificate of Death	Reg. No	2004 01301
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П			shocky or near taxure. List	complications that caused the death. Do only one cause on each line.	o not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between
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Physic /Med Exam	lical		23a. Party Enter the disease, or consider, or higher tailure. List only Immediate Cause (Final disease or condition resulting in death)	a	sed the death line.	tahic	er the mode of dy			VCL'NO			Approxim Interval B Onset and	etween
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17			30. Name and address of person who	completed cause of	of death (Iten	п 23а) (Туре,	Print)			0		4.	^ ^ '	2
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DA	ΔP	,	1- For Amend Item 24a per verb , 632, 03/12/04dib Certifica	ent of Health and Mate of Death	lental Hygie		07989
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1215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show he Modical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	2 No Specify:			ACK
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			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Penn Street, Ba	altimore,	Maryland	21201
	Sta Registi		31. Date filed (Month, Day, Year)				
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		Northwest Hospital Center Randalls town Balt										10/0
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п	Director		5. Social Security Number 6. Sex 1 M 2 7 Yrs. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Months Days Hours Min. 3 7 7 Yrs.									m) GA
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	다 다 0r28)Ire	10e. Street and Number			10f. Zip C	ode		10	g. Citizen of WI	nat Count	ry?
	23a	Funeral Director	3304 Ki	pole Ros	ad	1	151	4		4	SA	
	items	nei	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Deceder	nt of Hispanic Ori	igin? (Spec	rify Yes or No-	14. Race	- America White, e	in Indian,
9	afte or it		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No	5	1 ☐ Yes 2E			iouri, oto.)	Specify:		
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be motified at	d by	3 ₩idowed 4 Divorced	Year or Dates:			дио орослу.			эреспу.	ر ،	lack
5	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	edent's Usual (Occupation done during most	st of working	g 1	6b. Kind of Bus	iness/Ind	ustry
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2	filed within Hygiene ther then ont, the Me		121-	1	121	P = F	nology				>9 F	
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yla		ဥ	Julius Sta				L	419	Hes	5-1-12-1-		
Maryland	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship		19b. Mail	ing Address (S	treet and Numbe	er or Rural	Route Number,	City or Town, S	tate, Zip (Code) Z 1117
	an eath		Burnett M. Ll	oyd Sor) 800	C DE	164 64	ne	UWING	smil	m	٥. ٠٠٠٠
ore	90= 5		20a. Method of Disposition 1 Burial 2 Cremation 3	Ramoval from State	20b. Place of Disp cemetery, cre	osition (Name matory or othe	r place)	Da	8 -	c. Location - C	,	m, State
Ē	Pa men ant: ury		*4 □Donation 5 □ Other (Special		King Pa	-K	7	3-1-	04	Bylte	1	20)
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Lice	nsee	2	2. Name and	Address of Facility	y Uau	ish, CC	merce	F	unal Seri
0	Per Per Per Per Per Per Per Per Per Per		Muli Ka Ce	le_	Ş	18578	ibet	Re(Zundell	Stown	un	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused th	ne death. Do not en	iter the mode of	ol dying, such as	cardiac or	respiratory arres	it, <		Approximate
The same	Physician		Immediate Cause (Final			ce Co	sel					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	scleant consequence of):	Ca	V CICCIVE	Den	lan a	witch	_	
	Examiner			Rosma	a train	Fr.	0 1110					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of):	1000	2000				-	
	uted d apsit	표	Cause (Disease or injury that initiated events									
C.	exec in an ial-tr	Examine	resulting in death) Last	Due to (or as a	consequence of):						-	
8760	death certificate be executed e attending physician and nd for use as the buriat-transit	cal		d								
89	ificat phy s the			- U								
Box	leath certifical attending phy ifor use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. Il yes, outcome of	pregnancy					23d. Date	al deliver	,
m	atte atte	ciai	in the past 12 months?	1□Live birth 2 4□Pregnant at tir		□Ectopic pregr □ Other (specr				Month		y Day Year
P.O.	that the di ed by the detached	iysi	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown								
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions of	ontributing to death but	not resulting in the u	inderlying caus	se given in Part I.		23e. Did toba	cco use contrib	ute to the	cause of death?
ds	uires sigr d be	d by	Kidney i	riseare.					1 ☐ Yes	2 □ No 3	☐ Probal	oly 4 96/mknown
Ö	w require been si should	Completed										
3e	has has	ld m							24a. Was an autopsy	prid	or to com	sy lindings available pletion of cause of
<u>e</u>	cate ha	S							performe 1 ☐ Yes 24		th? Yes 2	□No
Division of Vital Records,	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Manital				of Death (Check only one)			
of	this cal dir	2	1 ☐ Yes 2 ☑ No	Hospital:				rsing Home	5 Residen	ce 6 □Other	(Specify)	
_	ing F	on	27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Y	/ear) 28b. Time o	ol 28c.	Injury at Work?	28	d. Describe how	injury occurred		
Sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b			М	1 Yes 2 N	No				
\leq	ter direct	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	r - At home, larm, st. (Specify)	reet, factory, of	fice	28	f. Location (Stree City or Town,		or Rural I	Route Number,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	Check only Z Medicel Exel	ysician: To the best of onliner: On the basis of ex	my knowledge, deat	h occurred at t	he time, date and	d place, an	d due to the cau	se(s) and mann	er as stat	ed.
	the P the F the F	led	2,	and manner state	d.			55561180	with the time, date	and place, and	1 G1 e 10 t	ie cause(s)
	To To	Σ	29b. Signature and title of certifier			29c. Li	cense number			Date signed (bruary 2		
			Lendu	100	00en	_ D	00581	41		Februa	7 4.00	24 2004
			30. Name and address of person who			Print)						
_			Wendie Will			Old <	ourt	R	dad	Randal	Stor	on, mo
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 2 2004	32. Registrar'	Signatur	1						
	nee ISU	-11	BINET TO COOT	Bush Man and and and and and and and and and a	- 1							

State of Maryland / Department of Health and Mental Hygiene 2004, 07991 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** March 5:45 A M Christopher Miguel Soto 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner National Institutes of Health Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs. 1994 Arizona Director 604-88-6907 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No San Diego San Diego Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 92126 8459 Aries Rd. USA or Items 23e Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: Puerto Rican 1⊠ Yes 2□ No þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student 2nd None 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any liury or other treumatic event OREs. 17. Father's Name (First, Middle, Last) Robert Soto Debra Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8459 Aries Rd. San Diego, CA. 92126 Robert Soto - father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🏝 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) East Lawn Palm Mort. 3-11-2004 Tucson, AZ, 21. Signature of Funeral Service Licensee Marshall s Funeral Home, Inc. 4217 9th St.N.W. Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Aviva complex infection 14 costetien Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine GARMA RECEPTOR 2 DEFICIENCY The law requires that the death certificate be executed burial-transit MTERFERON that initiated events resulting in death) Last P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Medical Certification: To Be Completed by THRONBOUTOPENIA, ANEMIA, HEPATOMEGALY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown INTESTINAL BLEEDING 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes certificate 2 No 1 Yes the Hospital or Attending Physician: After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 033322 03 04 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN HOLLAND Registrar's Signature 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 State Registrar

		State of Marylan	d / Depa	artment of h rtificate of	Health and	Mental Hyg	piene 2004	07992	
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Walter F. Siedlecki				2. Date of Deal Month		3. Time of Death	
Examin		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	la a biala da A	4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs. 8, Date of Birth			4c. County of Death n/a		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 12 M 2 F 7. Age (In yrs. 7. A		Months Days			, 1924 M	place (State or Foreign intry) aryland	
e Maryland la-f show	ctor	10a. State 10b. County 10c. Cit Maryland n/a	y, Town or Lo Balti	imore				10d. Inside City Limits 1 X Yes 2 □ No	
th with th 23a or 24	ai Dire	10e. Street and Number 1521 E. 35th Street		10f. Zip Code	21218	1	Og. Citizen of What Cou United S	-	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 ie marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U Armed Forces? 1 No It Yes, Give Year or Dates:	j	Was Decedent of Hif Yes, specify Cub		Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify: W		
21215-0036 ad within 72 hours afl gilene. er than 'natural', or i. The Medical Exorn.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 VYS.	orking	16b. Kind of Business/Industry Tavern					
Maryland 2 nd 2 should be filed tith and Mental Hyg 27 is marked othe traumatic event,	To Be C	17. Father's Name (First, Middle, Last) Adolph Siedlecki			Mar		Lachowski		
and 2 sh eaith and T 27 ie n		19a. Informant's Name/Relationship (Type, Print) Mrs. Alma Siedlecki / wife	1521	35th St		Baltimore	, City or Town, State, Zi , Maryland	21218	
Baltimore, Department of Hee Important: If them Any injury or other		1 M Burial 2 □ Cremation 3 □ Removal from State	emetery, crer	isition (Name of matory or other pla ary Cemet		Date 13/2004	20c. Location - City or T Dundalk, M		
Dait Deport		21. Signature of Funeral Service Licenses Michael E. Can	app ²²	Name and Address .eonard J			805 Harford Altimore, MI		
Physician /Medical Examiner physician and physician and the privat-transit	/Medical Examin	23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq of the conditions) of the conditions of the condition	TION uence of):		MONIA			Approximate Interval Between Onset and Death 2 days	
vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate reach: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of deput 10 □ Vinknown	death 3	Ectopic pregnance Other (specify)	У		23d. Date of deliv Month	ery Day Year	
cords, P.		Part II. Other significant conditions contributing to death but not resi	ulting in the u	nderlying cause giv	ven in Part I.		pacco use contribute to to		
Division of Vital Record or Attending Physician: The law requir after death. Director: After this certificate has been si d in by the funeral director, page 2 should	Completed					24a. Was at autops perform	y prior to co	opsy findings available impletion of cause of	
f Vital F ysician: Th us certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2	ER/Outpatien	nt 3□ DOA Oth	Ar:	eath <i>(Check only one</i> Home 5 Reside	e) ence 6 ⊡Other (Speci	fy)	
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific or mpletely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28b. Time of Injury	M 1	yat rk? Yes 2 ∐No		w injury occurred		
Divi		4 Homicide determined building, etc. (Specify	City or Town						
Div To the Hospital or Jo the Funeral Div To mpletely filled in I	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, death tion and/or inv	n occurred at the till vestigation, in my c	me, date and place pinion, death occ	ce, and due to the ca curred at the time, da	ause(s) and manner as s ate and place, and due t	stated. o the cause(s)	
To the I vulthin 2 To the Co. mplet	2	29b. Signature and title of certifier Source: Vels akay howers M	D	AT 2	4 3 8 9 4		9d. Date signed (Month, 8H		
6		30. Name and address of person who completed cause of death (Item	23a) (Type,	2011	N PMO EAST UNI	RIAL HOST VERSITY P	ITAL ARKWAY		
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signa MAR 1 2 2004		Says			272 3		

DHMH 17 Rev 1/2001

ORIGINAL

/Medi	ian cal	1- Statemend Item 3,23a, Statemend Item 2, Statemend Item 2, Statemend Item 2, Statemend Item 2, Statemend Item 2, Statemend Item 2, Statemend Item 2, Statemend Item 2, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 3,23a, Statemend Item 2,23a, Stateme	St) YAS SUM	MERVILL	E JR.		2. Date of D Month SANUA	eath Day Yea	3. Time of Death		
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Funeral		5. Social Security Number 6. Se		ge (In yrs. last birthday)	If Under 1 Ye			THE P			
Director		420 - 48 - 89 66 1 Usual Residence of Decedent	X M 2□F	6 4 Yrs.	Months Day	/s Hours Mi	n. (Month. D		irthplace (State or Fore Country) ALABAMA		
how		10a. State 10b. County	- 4 -	10c. City, Town or Lo					10d. Inside City Lim		
Ba-f a	Director	MD HARPO	060	F04	FWOOD				1 □ Yes 2 🗶		
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hours after death with the Maryland tural', or flams 23s or 28s-f show al Examinat must be truffled at	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	7	Was Decedent o	f Hispanic Origin? uban, Mexican, Pu	(Specify Yes or Ne		nerican Indian,		
I', or h	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 S Yes 2 □ If Yes, Give Year or Dates:	No I	1□Yes 2XIN		, , , , , , , , , , , , , , , , , , , ,		LACK		
natura lical E	ted	15. Decedent's Ed	ducation	16a, Dece	dent's Usual Occ	upation		16b. Kind of Busines			
han "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or :	D+)	Kind of work dor DO NOT use reti	ne during most of w red)	rorking	PEPT OF	·		
Hygier ther ti		12. y R S 17. Father's Name (First, Middle, Last)	ZYRS		>0 KEK	18 Mother's N	amo (Eirat Middle	TRAN , Maiden Sumame)	SPORTATI		
kad o	To Be			MERVILL	E SR.		A WAL				
and N is mar		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	ng Address (Stre	et and Number or I	Rural Route Numb	er, City or Town, State,	Zip Code)		
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artme ortani injury B.		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	_	22	Name and Add	ress of Facility		0 00000000			
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gned by the be detached	þ						24a. Was		utopsy findings availa completion of cause of		
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rate has been signed by the page 2 should be detached	Be Completed by	25. Was case referred to medical examiner?	Hospital:	pt 2 FP/Outpotion	27.004	ab a si	1 ☐ Yes eath (Check only o	ne)			
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State of Maryland / Department of Health and Mental Hygiene 00 1 07994 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) MERCH 21:12 M **Physician** John Bernard Tanner, III /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Medical Campus Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F 86 Maryland 218-01-1877 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Joppa Director Maruland Harkord 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21085 U.S.A. 1019 Old Joppa Road 14. Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 (X/Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Self-Employed Cotlege (1-4or 5+) Elementary/Secondary (0-12) Builder 6th Grade Builder Health and Mental Hygie tem 27 is marked other! 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Baltimore, Maryland be f Elizabeth Huber John Bernard Tanner, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra once. 1019 Old Joppa Rd., Joppa, MD Mrs. Cecelia B. Tanner. (wife) 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of h 1 XBurial 2 Cremation 3 Removal from State 3/12/2004 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph Ch. Cem. Fullerton, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Denature of Foreign Service License 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY FAILURE Immediate Cause (Final disease or condition resulting in death) HOURS Physician /Medical Due to (or as a consequence of): PANCYTOPENIA **Examiner** MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PARKINSONS DISEASE Due to (or as a consequence of) Examiner MONTHS attending physicien and for use as the burial-transit ENAL INSUFFICIENCY YEARS Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 No ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, John Bernard PARKINSONS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DYSPHAGIA, HYPOTHYROIDISM autopsy performed? Yes ENNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No 2ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours at To the Funeral D Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title 6 certilie 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and a press of person who completed cause of death (Item 23a) (Type, Print) UPPER CHESA DEAKE JOHN BYRNE D.O. 500 31. Date filed (Month, Day, Year) 32. Registrat's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

						Certi	ficate of	Death		Reg. No.	04	0/9	195
	Physici	an	1. Decedent's Name (First, Middle, La	•				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2. Dete of De Month	eeth Dev	Year	3. Time of	Death
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î	Examin	er	4e Fecility Neme (If not institution, gi						Location of Deet	h 4c. County	of Deeth		
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	Funeral Director			477 M G G G	1 yrs. lest bi		Months Days	Hours Min	. (Month, De	rth ey, <i>Year)</i> 3, 1921		lace (State o itry) nsy1va	
	land		10e. Stete 10b. County	10	c. City, Tov	vn or Locat	tion				1	0d. Inside Cit	ty Limits
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	r 28a	8	10e. Street end Number				10f. Zip Code			10g. Citizen of	What Cour	try?	
	h wit	2	867 Claffy Avenu	ie			210	54		USA			
	dea	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U,S.	13. Wa	s Decedent of H	ispanic Origin? (Specify Yes or No to Rican, etc.))- 14. Rad	e - Americ		
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Manyland Depertment of Health end Manial Hygiena. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at page.	þ	1 ☐ Never Married	1X Yes 2 No If Yes, Give Year or Dates: W	VII		Yes 2K No	Specify:	to rican, etc.)	Specif	ck, White, o	hite	
ر ک	72 h	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16e	. Deceden	t's Usual Occup	ation	nrkina	16b. Kind of B	usiness/Inc	ustry	
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<u>∞</u>	then 7 ie i		Mabel F. Tobin (• • •					ure/Route Numb mbrills,			Code)	
ē,	Heal Heal Hem 2	ŀ	20a. Method of Disposition		Ob. Place o	f Disposition	on (Name of			20c. Location -		wn State	
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	1000	-	23a. Pert1. Enter diseese, o com shock, or heart failure. List only	plications that caused the	death. Do				e, Annap) 214	U I Approximate	
9	Physician		shock, or heart failure. List only	one cause on each line.					,,		1	Interval Betw Onset and D	veen
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UNISION	Attending Physicien: ir death. ector: After this certific by the funeral director,	IICa	3 ☐ Suicide 6 ☐ Could not be		At home, fai			63 Z 🗆 NO	28f Location (S	Street and Number	er or Bural	Route Numb	or .
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	in 24 he Fu pletel	edical	(Check only 2 Medical Exam	iner: On the basis of exam and manner stated.	nination and	d/or investi	gation, in my op	inion, death occu	rred at the time, o	date and place, a	nd due to t	ne cause(s)	
	t of the contract of the contr		29b. Signature and title of certifier	1) 1			29c. License			29d. Date signed			,
	,		1 am Con	allaur	w		D3	1136	1	MARCH	8 6	2004	1
	16		30. Neme end eddress of person who o	completed cause of death ((Item 23e) (Type, Print	0 0	. 0 / 0	040, NO		(5)		
			DRIAN (-WAL	LACE WAD	400	5	SILBR	IDE R	040, NO	ITINGH	FW M	1) 212	36
	State	7	31. Dete filed (Month, Machine)	200 432. Registrars S	ignature	6			*		1		

DHMH 16 Rev 6/95

		1	For State Registrar	State of Marylar	nd / Depa <i>Ce</i> a	artment of Health rtificate of Deal	n and Mental Hy th	ygiene 200	4 07996
	Physicia		Decedent's Name (First, Middle, Las	t)		14/-11-	2. Date of D Month	Peath Day Yea	3. Time of Death
7	/Medic	al	4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or Location		4c. County of De	
		-	1	okins Hospi		Ballimore If Under 1 Year If Under	C. Ly der 24 Hrs. 8, Date of B	NA 9.8	irthplece (State or Foreign
В	Funeral Director		248-26-0855	M 2□ F 83	Yrs.	Months Days Hour	rs Min. (Month, D 12–20	Dey, Year) (Country)
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation			10d. Inside City Limits
	88-f st	ctor	Md. NA		Baltin	1		10- 00	1√ Yes 2 □ No
	with the	Funeral Director	10e. Street and Number 2622 E. Federal S	Street		10f. Zip Code 21213		10g. Citizen of What OUSA	country?
	deeth	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yes or Nican, Puerto Rican, etc.)	Io- 14. Race - Ar Black, Wi	nencan Indian, nite, etc.
36	be fited within 72 hours after deeth with the Maryland stat Hyglene. ed other then "naturel", or Items 23a or 28a-f show event, the Madical Examiner must be natilised at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 → Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Spec		Specify: B1	
Maryland 21215-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occupation kind of work done during n	nost of working	16b. Kind of Busines	s/Industry
121	within iene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		po NOT use retired)		STA	
nd 2	be filed tat Hygie d other event, III	Be Co	6th grade 17. Father's Name (First, Middle, Last)		UOII		other's Name (First, Middi		
ylaı	should be nd Mental. marked o	To	Unkn	People		Mong Address (Street and Nu	arie	Hewlett	Zin Code)
	O. 02 00 0		19a. Informant's Name/Relationship (1) Aldrenna Williams	•		Mahogn Dr.,			, 216 0000)
Baltimore,	of Health of Health if Item 27 i		20a. Method of Disposition 1 Burial 2 Cremation 3	20b.	Place of Dispo cemetery, cre	sition (Name of matory or other place)	Date	20c. Location - City	or Town, State
Iti m	permit. Pages Department of I Important: If It any injury or o		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Euneral Service Licen) Gar		Forest Vet. 2. Name and Address of Fa	-10a	Owings M	
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9			23a. Pert1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the dea one cause on each line.	ith. Do not en				Approximate Interval Between Onset and Death
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6	icate be executed physicien and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conse	quence of):				
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Box (eath certifi attending I for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		□Ectopic pregnancy		23d. Date of o	
.O. B	he deat the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (specify)		Month	Day Year
Ω.	res that the de igned by the a be detached t	by Ph	Part II. Other significant conditions of	ontributing to death but not re	sulting in the	inderlying cause given in P	art I. 23e. Dic	tobacco use contribute	to the cause of death?
ords	w require been sig should b						10		Perbably 4 ☐Unknown
Records,	e la has	Completed					per	topsy formed? prior t death	
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of V	S S D	2	1 Yes 2 to	Hospital: 1 atient 2	ER/Outpatie	The second second	Nursing Home 5 Re	sidence 6 Other (S	pecify)
lon	frer frer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	of 28c. Injury at Work? M 1 ☐ Yes 2	_	o now injury occurred	
Division	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A campletely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		home, farm, s	reet, factory, office	28f. Location City or 7	(Street and Number or own, State)	Rural Route Number,
۵	spitel cours at neral D		29a. Certifier 1 Certifying Ph	nysician: To the best of my kr	nowledge, dea	th occurred at the time, date	e and place, and due to th	e cause(s) and manner	as stated.
	the Ho iin 24 h the Fui	Medical	one)	niner: On the basis of examir and manner stated.	nation and/or i				
	of the state of th	2	29b. Signature and title of certifier	2		29c. License numb		29d. Date signed (Mc	- · · · · · · · · · · · · · · · · · · ·
	5+1		30. Name and address of person who	completed cause of death (Ite	əm 23a) (Type	RES - 00		<u> </u>	
)		Conthia D Ruler	The Johns	Hockin	s Hospital Bu	ON Wolfe:	St Baltivan	MO 21207
	St Regist	ate rar	Conthia D. Rulker 31. Date filed (Month, Day, Year) MAR 1 2	2004 Same	mar /	& Sports	/ *		

State of Maryland / Department of Health and Mental Hygiene 2004 07997 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2004 **Physician** Year March 9, Whithorn Mary 10:20P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Cromwell Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 31, 1948 If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F 55 214-50-6294 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or items 23a or 28e-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 239 Trappe Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 À 1 ☐ Yes 2 No Specify Specify: 3X Widowed 4 □ Divorced White "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien-importent: If item 27 is marked other thu any injury or other treumatic avent 11 Years Dispatcher Cab Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Moyer James Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 Mrs. Tanya King / Daughter 8033 Mid Haven Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 12 Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 3/13/2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Singular ture of Funeral Service Licensee 22 Name and Address of Facility al Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Olrhery July may Mesere) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physicien Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Q Inknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 24a. Was an autopsy page med? 2G No 1 ☐ Yes 2 X No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Other: 4 V Nursing Home 5 Residence 6 Other (Specify) 2 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after uver...
To the Funerel Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) MHINH RAMINA 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registra 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 113 Pauline Watts /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 77 216-20-6321 Director Maryland March 8,1927 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28a-1 show any injury or other traumatic event, the Medical Examinise must be notified at tXXes 2 No Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 United States 635 South Lehigh Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White à 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 Vrs. College (1-4or 5+) Restaurant Waitress yrs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Grace Underwood Gilbert Mets 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 1701 Charlotte Avenue Baltimore, Mary Iand 21224 Sandra Kosmaczewski/Niece 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete 20a. Method of Disposition cemetery, crematory or other place)
Hilltop Service Corp. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 3/15/2004 Towson, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 2122 ile Marca 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** STAPHY WED COUS BATTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner STABE burial-transit physician s the burial 2 WEXS Box 68760 99 The law requires that the death certificate as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day for in the past 12 months? 1 ☐ Yes 2 XNo 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 🗌 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Minpatient P 2 ER/Outpatient 3 DOA this After this funeral c 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification; 5 Pending investigation 1 Natural t hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number AT 2438946 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) BMDHUME, MD 21218 UNIVERSIN MILWAY 201 PORTO CARRETRE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2001 07999 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 01 ler 3:30 PM Jani March 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital Baltimore Sinai If Under 1 Year If Under 24 Hrs. / Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 10M 20F Months 19-32-9395 Director Usual Residence of Decedent 10b Counts 10c. City, Town or Location 10d. Inside City Limits 10a State 28e-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No Director CI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 elson 1215 "naturel", or items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: a þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neny injury or other traumatic event, Its Mediance. Elementary/Secondary (0-12) College (1-4or 5+) DTON eada 'ew 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be alker 5 Kosale Nathaniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's, Name/Relationship (Type, Print) 5 426 Nelson AVe MUD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Naurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) -13-04 MARulan Druid Judy Fllmerel 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4 PSERTY Nell 600 MD 2120 141 2010 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 certificate be Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1 Yes tuneral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 Impatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 3□ DQA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospitel or Attending 5 Pending death. 1 🗌 Yes 2 No investigation 2 Accident after death Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours at To the Funeral D. 29a. Certifier l 🖟 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified Murch 9, 2004 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jinai Hos Suna

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 2 2004

Walker

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 20011 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death White **Physician** revalding Month Year 2000 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ealthcare Bottimere If Under 1 Year | If Under 24 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Gountry) **Funeral** Hours Min. 1 M 2 F 24--Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County or 28a-f ehow 10d. Inside City Limits traumatic event, the Medical Exeminer ount be notified at 1 ☐Yes 2 ☐ No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21133 or iteme 23a Completed by Funeral . Was Decedent Eyer in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or ite Black, White, etc. 1 New Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0,12) 12th Grade Homemakes College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lows labb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Deportment of Health ar Important: If item 27 is any njury or other trau once. 20b. Place of Disposition (Name of cemetery, cramatory or other p 20a. Method of Disposition Date Town, Stete 1 Burial 2 ☐ Cremation 3 □Removal from State voitus Men. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service to nsee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Or set and Death Immediate Cause (Final disease or condition resulting in death) Due ti (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Medical Certification: To Be Completed by Physician/Medical Examiner 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death

Yes 2 □ No autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA ō ieral Director: After th 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to the Hospital The crititying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Dey, Year) MARCH 4, 2004 E. REED, M.O. (Type, Print) HEALTHE T. AGNES TIMORE, MOZIZZA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 2 2004 Registrar